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SOCIAL WORK INTERVENTION WITH THE OLDER FAMILY

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INTRODUCTION

The practice setting on which this report is based is the St. Boniface Extended Care Day Hospital. The writer provided social work service to eight older families whose individual members were attending because of various physical and emotional difficulties. The practice was conducted from October, 1976 to April, 1977.

The day hospital serves as a vitally important link to older families, both as a source of prevention of long-term hospitalization for their aged people and as a means of maintaining older persons in their family settings. It also serves individual old people who may not have interested or available family. Old people present to the day hospital with a variety of needs ranging from physical rehabilitation, to social stimulation, to help with adjustment with the numerous changes associated with the aging process. The services are provided by a multi-disciplinary team which consists of Physio and Occupational Therapy, Social Work, Medicine, Nursing, Activities, and Dietetics.

Social work intervention, as used in this review, denotes a broad array of activity and service provided to members of older families. It includes provision of practical resources, referral to appropriate community supports, help in coping with the anxieties associated with an aging parent or spouse, participation in a health team, and contracting with family systems to promote behavioural and attitudinal change, where this is possible. Intervention is not confined to therapy only, although the term is used at various points, usually by writers who view their role

with older families in the narrower interpersonal framework of the treatment of family dysfunction.

The purpose of the practicum was to achieve the following:

1. to become familiar with relevant literature pertaining to the psycho-social aspects of aging in a family context

2. to become familiar with various models of family intervention relevant to the aged family system

3. to learn about conducting family practice of this type within the modality of a multidisciplinary team

4. to obtain feedback from the clients and team concerning the writer's intervention.

CHAPTER 1

Rationale

The main focus of this practicum report is an examination of some of the relevant literature pertaining to families in the adult-child-aging parent stage of the life cycle. The literature review will be divided into separate sections on the aged parent, the middle-aged adult child, and on the changing relationship between the two. Next, appears a chapter on crises in the older family, followed by a chapter on issues and strategies pertaining to intervention. Another chapter will be devoted to an integration of the relevant concepts contained in the literature review to the practice conducted by the writer with families at the St. Boniface Day Hospital. The report will contain two additional chapters, one, a description of the day hospital setting and of the multidisciplinary team working within it, and another, a summary of the writer's conclusions arising from the work he has done.

> For those engaged in family treatment, older families and intergenerational family relationships are in the main a clinical frontier... (Spark and Brody, 1969, p.196)

This statement seems to be an accurate representation of the state of affairs that currently exists regarding theoretical and practical knowledge related to older families. Other writers in the field of gerontology have commented on the lack of attention by the helping professions to old people and their relationships. James Peterson has noted "... To date this sector has been ignored both in research and in treatment by family experts, psychologists and psychiatrists " (In Schwartz and Mensh,

eds., 1974, p. 240). He also wonders about the lack of available literature on the inclusion of the older person's family in therapeutic sessions. In short, the helping process with the aged family presents a challenge to the whole human service community.

The challenge is there because there has been in the past seventy years a marked increase in the number of people surviving to old age and a corresponding increase in the number of three and four generation families. Townsend (1966, p. 255) commented on the existence of four generation families on a large scale as a new phenomenon in the history of human society. He attributes this change to improvements in longevity, the dramatic drop in the average age at first marriage, and diminishing of the average age of parenthood. The result of these new patterns has been a narrowing of the average span in years between successive generations. Concomitant with these new familial relationships there has developed a considerably altered experience of aging. Townsend argues that the family of the post-industrial era, compared to that of a hundred years ago, is very different. Whereas in the former society old age had a certain prestige attached to it, especially where there was one surviving grandparent at the top of the family pyramid, now there may be two, three, or all four grandparents alive and often a great-grandparent too. Shanas, (1968) in a cross-national study of persons aged 65 and over (including the United States, Denmark, and Britian), found a significant number of the elderly with great-grandchildren - 40 percent in the United States, 23 percent in Denmark, and 22 percent in Britian. These factors combine to create greater complications in the interactions of

the various generations. Townsend believes that a greater emphasis will be placed by gerontologists in the future on the reciprocal relations between the third and fourth generations. Another effect in his view is the establishment on a large scale for the first time of a generation of relatively frail people. Brody (1972, p. 24), documents this recent phenomenon:

> With the entry into the category of advanced old age of an increasing proportion of people [in the decade between 1960 and 1970, the 75 and over group increased at three times the rate of the 65-74 group (7)], more experience the loss of adult children who themselves are middle-aged and even aged.

The facts that in 1900 the average human life span was 47 years and only 4 percent of the population were 65 and older and that today, with improved rates of infant mortality in much of the industrialized world, the average life expectancy has increased to 71 years and that the elderly now represent 10 percent of the population, all reflect a revolution in the extended family structure (Butler, 1973, p. 5). Townsend comments:

> The nature of the problems of old age is therefore changing... A common instance of the future will be the woman of 60 faced with the problem of caring for an infirm mother in her eighties. The four generations of surviving relatives may tend to separate into two semi-independent groupings - each of two generations. Similarly, there may be a shift of emphasis from the problem of which of the children looks after a widowed parent to the problem of how a middle-aged man and wife can reconcile dependent relationships with both sets of parents. (1968, pp. 256-7).

These organizational and structural variations in the family will be of urgent priority for social workers who deal with the stresses related to an increase in the number of very old people and the effects the increase may have on significant kin, extended or immediate. Townsend, like Peterson, calls for more concentration from the helping professions on

this aspect of the modern family.

> Insufficient attention has been paid to them (changes in the population of the aged) in discussing relationships between parents and their children, between husbands and wives, between generations and generally among households and families... (1968, p. 257).

What are Older Families?

What is meant by the term 'older family'? Since there is no very precise usage of the term in the available literature, a range of possible meanings will be proposed. Part of the difficulty in developing an accurate enunciation of 'old' in a family situation is related to the variation in interpretation among writers when they are describing old age. Growing older, aging, being middle aged, becoming elderly, are not exclusive categories and the specific sense of each of these is dependent on the particular discipline or individual that happens to be engaged in using the words. To complicate matters even further, aging as a process is considered to be something all human beings begin to do from the moment of birth (Butler, 1973, p. 4) so that designating older families from younger may be seen as inappropriate.

Despite these problems of interpretation, an old family may be understood as the parent and his spouse who are in their seventies or more, the adult child, and his family. At times during the report, it may also mean just the old couple; at times it can be the adult children and their families, siblings and extended kin; at times it may be the relations of the four generations at important interfaces, (i.e., the health breakdown of the seventy-year-old parent, and the effects on the adult children

and grandchildren).

Kimmel (1974, p. 215) uses the term 'aging family' to describe the final period of the family cycle. It is marked, he holds, by the retirement of the husband and major role changes for both parties. (Role change will be discussed in more detail in a later section). Accompanying the retirement of one or both spouses often is a decline in income, sometimes cut by one-third or one-half (Maddox, 1966). As well, during this period a change of residence from the family home which may become too much for the couple to handle, often occurs. Finally, great-grandparenthood may be another new role for an increasing number of older family members.

It will be seen that the sense of 'older family' which the writer is using and that which Kimmel offers have somewhat different emphases - Kimmel is thinking of 'family' in the sense of a series of developmental stages ranging from parenthood, empty nest (last child leaving home, usually when the couple is approaching their fifties), and retirement. The sense of the older family as conceived in this report is as both a stage or natural progression in life and as the specific combinations of relationships - i.e., aged parents and their adult children, the interrelationship of the four generations, etc.

These meanings need to be distinguished from the typical ways in which the 'family' has been traditionally studied by social scientists:

> The tendency to neglect the later phases of the life cycle as these pertain to intergenerational relations stems in part from the overemphasis in the social and psychological sciences on the early stages of the family. The social and emotional problems of older persons have received less attention. (Streib and Shanas, 1965, p. 3).

The isolated nuclear family has been the one with which social scientists and practitioners have traditionally concerned themselves. Recent challenges to Parson's notion (1955) of the nuclear family as the most functional type for modern industrial society by such writers as Litwak (in Shanas, 1965, pp. 299-323) and Sussman (1962, pp. 231-240), have broadened the concept of the modern family to include the connections with the family of origin. Traditionally, then, in the helping professions, there has been a concentration on the family of procreation while the extended relations have not been given as full a weighting.

Indeed social work has been soundly chastised for its failure to become involved sufficiently with old clients and their families. Blenkner has been scathing in her denunciation of this omission:

> Social-work theory and practice is oriented to the individual and to the nuclear family, composed of husband, wife, and young children. Its theories of intrapersonal and intrafamilial dynamics are almost entirely derived from psychoanalytic models, largely Freudian. In addition, of late, role theory[1], crisis theory[2], and transaction theory[3] have made their appearances on the social-work scene, but all are used within, and adumbrated by, the basic Freudian psychology - a psychology which views the apex of human development as that of "genital maturity" which, in the healthy personality, is attained in early adulthood and which, among other things, involves freeing oneself of the parental tie. (Blenkner, 1965, pp. 46-47).

Even with the development of Family Systems Theory in recent years and with the greater emphasis on a total family approach to individual problems, there has been a limited application of this framework to the middle-aged and aged family members. Spark and Brody (1969) have commented on the slow movement among professionals toward applying a Systems approach to third and fourth generations:

> The family approach shifted the therapeutic focus from the individual to the family as a whole. Till now, concentration has been primarily on the family in its relatively early phases, reflecting the same preoccupation on the part of theoreticians, researchers, and practitioners in the psychological and social sciences. An additional shift in perspective is suggested so that the conceptual framework includes all generations, even those legitimate family members, the aged. (Spark and Brody, 1969, pp. 195-209).

Indeed the work of Grauer, Betts and Burnbom reinforces Spark and Brody's assertion:

> The concept of family therapy is now well established on this continent...although family dynamics focusing on the aged patient have been explored and reported in the literature (1-5) we have not been able to find a description of progressive family treatment involving the aged. (Grauer and others, 1973, p. 21).

To complete the differentiation that is being made here between old and young families, it may be useful to summarize what has been contended to this juncture. Old families signify the stage at the upper end of the life cycle when the marital pair reaches retirement. Old families may also mean the sets of relationships occurring for people during this critical life phase: elderly couple, aged parents and adult children, and extended kin relations. Young families denote the married couple at such crucial early life stages as new parenthood, families with preschool children, and families with adolescents (Kimmel, 1974, pp. 201-210). The term 'family' has tended, until the last decade, to indicate these early phases of the life span and without much connection to one's family of origin or to the extended kinship bonds.

CHAPTER 2

Aging from the Aged Parent's Framework
or
No Need to Bother, He's Just an Old Man

There are a number of factors which can combine to make life unpleasant for the aged parent and his family. This section will attempt to expand on those issues in the process of growing old that tend to have a negative effect and that, in combination, may result in the family members calling for help from the professional community. It has been the writer's observation, both in the institutional setting of the practicum and in a community-based service for the elderly, that outside agents are not usually summoned until there is some serious difficulty that the family finds itself unable to handle. What are some of these difficulties? What are the negative changes associated with aging that become too much for families to handle? It is the writer's opinion that part of the answer may lie in the adult child's and parent's orientation to becoming old. In short, a distinction may need to be drawn between the realities associated with aging and the societal stereotypes which are shared by many families toward the idea of age. These stereotypes may interfere with the capacity of families to deal with their aged members when stresses on the parent intensify.

There are many levels on which the examination of misunderstanding toward aging can be performed. In the discussion that follows some of the common social stereotypes will be considered. It will be argued that

these broad misconceptions have their effect on the aged parent, his family, and on the attitudes of professionals who work with aged people as clients.

People who are reaching retirement or who are somewhere further along in the stages of later old age find themselves confronted by a peculiar mixture of positive images such as the 'golden years' or 'harvest years' all mixed together with an extremely dark picture of illness, isolation, and negative change. In reality, aging may be a time of considerable stress. Tiven (1971, p. 34) asserts that it is the stresses associated with aging which may cause the depression, anxiety, paranoia, and psychosomatic illnesses that are often associated with older patients and assigned in a blanket fashion to the aging process. Neither extreme, blissfulness on the one hand, nor unrelenting misery on the other, can account adequately for the rich and subtle variations that exist for people who are in this life stage.

Another myth is that of the inevitable slowing down and reduced competence of the elderly. The aged are believed by many to think more slowly and less creatively. It is assumed that they cannot learn as well as younger persons and that they all tend to become self-centered and bound to the past. The following portrayal is a kind of synthesis of the inevitability myth:

> ...Tied to his personal traditions and growing conservatism, he dislikes innovations...Not only can he not move forward, but he often moves backward, he enters a second childhood....He becomes irritable and cantankerous, yet shallow and enfeebled...enfeebled, uninteresting he awaits his death, a burden to society, to his family, and to himself. (Butler, 1970, mimeographed).

The foregoing implies that all old people are similar, that all aging involves irreversible illnesses, and that old people are rigid, unchangeable, and dependent.

In terms of the reduction in intelligence, Lawton (1975) has argued that psychologists have treated the old person unjustly in their production of a long series of cross-sectional studies comparing the performance of groups differing in age on a variety of cognitive and personality tests. The older person usually emerges second-best compared to younger age groups. In this way they (the psychologists) have contributed to these negative myths, he believes. Lawton expands this point by reviewing some recent research which shows that the amount of deficit attributed to aging has been overstated:

> ...More recently some of the damage done by interpreting these apparent age differences as intrinsic to the process of aging has been undone by research showing the contributions of such factors as education, other past experience, physical health, chronic brain syndrome, amount of recent practice, and social deprivation to the observed differences... (Lawton, 1975, p. 1).

Studies in perception (Rees and Botwinick, 1971, pp. 133-136), problem-solving (Arenberg, 1968, pp. 500-510), and learning (Canestrari, 1963, pp. 165-168) reveal that errors made by old people are more likely to be errors of omission than of commission. These results are in line with the position that it is safer for an older respondent to avoid an overt mistake by withdrawing and in so doing, to avoid having his incompetence (as defined by the studies) exposed. Eisdorfer, Nowlin, and Wilkie (1970, pp. 1327-1329) have suggested that anxiety is a possible reason for withholding a response while Botwinick (1966, pp. 347-353) has claimed

that older people may have a tendency not to take risks on these tests and avoid the shame of error. Indeed, as Lawton maintains, it is likely that older clients in a therapeutic relationship may be reluctant to reveal too much for fear of making a mistake because they have responded to the social expectation that the aged are always making mistakes.

Riley and Foner (1968) have compiled an interesting array of research findings on middle-aged and older people. The results in a number of areas point to the falsity of the inevitable-decline myth that old people all undergo severe reduction in general functioning:

> ...The older worker's productivity shows no consistent decline. Scholarship is maintained at a fairly high level into old age. There is little evidence that aging brings sexual impotence. The typical older person seems to have a strong sense of his own worth, to minimize his self-doubts, and not to even regard himself as old. (Riley and Foner, 1968, p. 7).

Perhaps even more to the point is the fact that there may not be a 'typical old person'. The post-sixty-five group seems to have great diversity of behaviour, self-concepts, and ranges of function and these may depend upon the unique combinations of factors such as personal history, finances, health, and family supports.

The public image of inevitable illness attached to the aged does not correspond to the realities which have become revealed by medical and biological investigation. Often illness and age become synonomous in the public imagination. Yet, this equation is not justified. Verwoerdt (1976, p. 4) adds some valuable qualifications to the idea that old age means increasing illness and decrepitude. He applies the concept of

homeostasis to the state of being healthy. One way of defining health, he maintains, is the ability to maintain an equilibrium between oneself and the environment. This ability has been referred to as homeostasis. As one's age advances one's capacity to adjust to external circumstances may decline. However, even though the range of adjustment becomes narrower, aged persons can still adjust to both bodily alterations and to changing circumstnaces.

Verwoerdt defines aging as "...the progressive loss of psychological capacities and functions in the organism" (1976, p. 4). While some deterioration is age-related (such as calcification of the arteries, for example), there is no automatic cause and effect relationship between aging and disease. This matter has important implications for social workers and other practitioners who service the elderly, because thinking so narrowly can foster very limited prognosis and even discourage involvement. For social workers, there has been a reluctance to practice with the aged partially because of these societal beliefs in inevitable decline and disease-proneness. As Brearly has remarked: "...it is not easy to see death as a success for social work treatment" (1975, p. 3). Another consequence of the tendency to 'lump' illness and age into one category is that insufficient attention is given to investigation of healthy old people (Butler, 1970, p. 18). This can have a self-fulfilling effect in that not enough work may be devoted to study and treatment of disease in the elderly, and the results of limited positive outcome based on narrow samples of sick and/or institutionalized clients inevitably reinforces

the conviction that old people are not worth the investment of medical time.

One stereotype that needs to be laid to rest is the 'brain damage' myth. It is often an implicit belief that all people have damage to the brain as a result of aging. Senility is a term often used by doctors and lay people alike to explain both the behaviour and condition of the elderly. Butler (1973, p. 22) has demonstrated that many of the reactive emotional responses of old people such as depression, grief, and anxiety are labeled senile and considered untreatable states. Senility, meaning age or characteristics of old age, (Webster's New Collegiate Dictionary, 1961) becomes a convenient label for avoiding diagnosis and treatment. Brain syndromes, both the irreversible and reversible types, become incorrectly referred to by many laymen and medical personnel as senility. What the intervention agent must understand is that neither brain damage nor aging explain all the occurrences of mental conditions among older people (Saul, 1974, p. 23).

When we attempt to sort out the true nature of aging with all its variations, it is striking how significant is the complex overlay of factors contributing to psychological health in old people.

Characteristics which have often been regarded as inevitable attachments to chronological age, such as memory loss and inability to learn or perform new tasks, in fact, may be highly dependent on personal circumstances and the state of physical health. Arsenian points out that "...every person has a breaking point...influenced by critical events in living, their timing and...cumulative and counteractive effects" (1962, p. 667).

Closely related to the myths of aging as a disease process and a time of irreversible decline is the strongly held position of unresponsiveness to therapy. Partially because of improper application of the senility category to various conditions of old age, mental or emotional disorders among the aged are sometimes seen as physical in origin and therefore, beyond the scope of psychiatric treatment. With regard to brain deterioration in old people, the United States Department of Health (1963) advises that when there is a dysfunction related to brain damage it is not uaually because of advancing age but is more likely related to some disease process.

Lack of access to assistance for psychological difficulties would appear to be a major issue for people once they reach sixty years and over. Ronch and Maizler (1977, p. 276) report that only 2.4 percent of all patients over 65 are seen in outpatient mental health clinics in the United States, while approximately 2 percent of private psychiatry has been found to be devoted to this group. Contrasted with these figures are data from the National Institute of Mental Health (World Health Organization, 1959) which reveal that new evidence of cases of psychopathology are 236.1 per 100,000 population in persons over 65 while it is 93.0 per 100,000 population for the 35 to 54 age group. This lack of mental health service to older people may reflect the implicit belief that the aged are basically untreatable. Pfeiffer (personal copy, source unknown) blames psychiatry for creating the myth that elderly patients are not amenable to psychotherapy. Freud's belief that old people are no longer educable seems to have been accepted by psychiatrists and

psychotherapists, perhaps because it fitted in nicely with their own prejudices about the elderly. Whatever the precise reasons are that psychological help has been denied the elderly - Lawton (1975, p. 3) reminds us that psychological assistance may be distasteful to present-day 70-year-olds because of their lack of socialization towards any form of professional help - the image of unsuitability for intervention does them a disservice. We in the helping professions should not use an older person's possible unfamiliarity with therapy as an excuse for not offering help but rather should be attempting to develop modifications that will be relevant to his needs. While hard data on the responsiveness of old people to treatment are scarce, some positive results have been found. The Group for the Advancement of Psychiatry (1965, p. 567) maintains that "few older patients are truly rigid, unchangeable, stubbornly negativistic or unresponsive to skilled concern". Goldberg (1970). found in her study of social work effectiveness with 150 old people in London that a variety of inputs including both practical help and casework intervention accomplished greater satisfaction with life, more activity, less depression, and fewer worries. (A control group was provided with only standard and more limited social welfare services). These results certainly encourage the view that psychic growth is possible at all stages of life.

Flowing into the discussion on unfavourable stereotypic stances adopted toward aging is the notion of ageism - a term coined by Butler (1973, p. IX of Preface):

> A systematic stereotyping of and discrimination against people because they are old...allows the younger generations to see older people as different from themselves; thus they subtly cease to identify with their elders as human beings...

There are numerous sources for this sort of judgement. The emphasis on youth as a desirable state within society is one. The inevitable connection made by many of us between aging and death, and a generalized tendency to maintain death-related issues at arm's length, conveniently in the jurisdiction of old age, are others. The well-entrenched relationship between modern industrial status, high productivity, and a lower value given people in the over-55 brackets who are less able to compete with their younger counterparts, is supported by many students of aging. Cowgill and Holmes (1972, p. 9) have compared highly industrialized societies and primitive, non-literate societies. Their analysis suggests that old age becomes less valued as the degree of modernization increases. Disengagement or withdrawal of the elderly from meaningful activity and roles is not typical of the aged in primitive or agrarian societies but becomes increasingly apparent in more modernized cultures. The status of the aged tends to be higher where they continue to perform valued functions, usually in less literate, more stable societies that are not undergoing rapid social change. The authors have drawn several conclusions of note. As technology advances and as more people survive to greater old age, there may be a coincident lessening of the status assigned to it. They acknowledge, however, that the individualistic value system characteristic of the modern culture that stresses independent achievement and responsibility is changing to one that allows for more shared responsibility

for all. Certainly the tendency to 'write off' people as worthwhile because of a reduced capacity to have marketable skills has contributed to a devaluation of the aged, as well as other minority groups such as the poor, and women.

The charge made by so many social commentators that ours is a youth-oriented culture which has rewarded physical vigor and youthful beauty at the expense of older age groups, is almost a cliche by now. Some of this youth orientation is expressed in expectations that sexual behaviour among people as they enter their 50's and 60's is inappropriate. While it is true that sexual activity does show change over time, no basis seems to exist for believing, as many of us do, that old people automatically lose their sexual drive:

> Sexual needs and desires do not undergo an abrupt change with advancing years....Abrupt loss of desire is generally symptomatic of psychological factors.
>
> However, society, including the aged, lacks general understanding of sexual urges, capacities, and expressions in older people. Social conditioning is a particularly important factor in the sexual attitudes and practises of older persons....Well-adjusted persons do not have sexual problems because of aging. (U. S. Department of Health, Education, and Welfare, 1966, p. 39).

This society-wide view of the elderly as not having a legitimate interest in sexual relations robs them of yet another part of their humanness and adds to the 'we-they' phenomenon of generational difference. This rejection of sexuality becomes enacted in such images as 'the dirty old man'. Indeed, age-appropriate norms seem to weigh heavily on many of the elderly not only in the realm of sexual behaviour but in areas of dress, style, general attitudes, and activity. A crucial concern for interventionists is the degree to which the aged may adopt the negative or

restrictive prescription for living that the dominant culture defines for them. Typical of these age-related constraints is the shock reaction that families sometimes display when an elderly widower-father decides to court a new partner or when two older people in a nursing home are discovered engaging in sexual activity. While there is some research to show that older people will tend to resist these prejudices even to the point of not perceiving of themselves as old, (Riley and Foner, 1968, p. 7) such a response to the issue may only serve to reinforce the denial of aging as a natural, life-long, valid process. It may be the ultimate irony that the healthy, functioning, ideal old person in terms of societal mythology, if there is such an ideal, is someone who does not 'look his years', who has somehow 'escaped becoming old'.

Rose (1968, pp. 29-34) has postulated the existence of a sub-culture among the elderly arising out of a common affinity based on a shared background and exclusion from interaction with other groups in the population. He applies the term 'group self-hatred' to the elderly:

> ...I mean a strongly negative attitude toward the self because one has a negative attitude toward the group or category which nature and society combine to place one in...

He develops this analysis further in describing the process by which Americans come to view themselves as old:

> ...There tends to be a marked change in self-conception which includes a shift in the thinking of oneself as progressively physically and mentally handicapped, from independent to dependent, and from aspiring to declining. Because most of the changes associated with the acquisition of the role and self-conception of being elderly are negatively evaluated in American culture, and because there is no compensatory attribution of prestige, as in other societies, the first reaction of most older people is some kind of disengagement and depression.

A couple seen by this worker provides an example of how the elderly can too easily accept the projected norms of their social system pertaining to appropriate conduct and the potentially destructive effect such introjection can have. An eighty-year-old man had suffered a stroke which left him partially paralyzed but still with quite good mobility. The wife, upon the husband's return from hospital and upon being advised by her daughter that - "Dad needs his own room now; he's a sick man so you'd better let him be by himself," promptly followed the daughter's advice. When asked by the writer whether she had consulted her husband about this rather major move (they had shared the same bed for fifty years of married life!) stated: "No, but I just thought it was the proper thing to do; besides my daughter said it would be best to do it this way." Such well-intentioned concern for someone older (in this case, a person trying to recover from a serious illness) can overlook the real needs that couples have for intimacy, support, and sharing, at all ages whether sick or well. How can we be sure that such arbitrary standards, imposed because of some implicit code that it is not proper for two older persons to remain sexually active while one is recovering from a stroke, may not only serve to reinforce the image to the victim that he should withdraw an appropriate distance from the rest of the world?

We have been examining the broad imagery of aging as it relates to the aged parent and have observed how these perceptions, often based on inaccurate information and on anti-aged world-view, can become absorbed by older people into their own belief systems. We have looked at the way in which the mythology becomes used by the helping professions who are involved

with the elderly. We have contrasted these images with the realities borne from some systematic studies of aging. We need now to consider the importance of age-based distortions toward older families to discover ways in which they may affect attitudes of helpers, family members, and the public at large.

It is commonly believed that families abandon their elderly when the latter become bed-ridden or destitute. Sussman (1965) has helped to correct this half-truth. He has challenged the rigid nuclear family portrayal of modern society with its model of emotional self-sufficiency which excludes extended members. While there exists a pattern of separate households for parents and grandparents, there is strong empirical evidence of viable helping family relationships. Sussman calls this an "...extended kin-family system, highly integrated within a network of social relationships and mutual assistance that operates along bilateral kin lines and vertically over several generations" (1965, p. 63).

The belief in family rejection of old parents, according to Shanas (1963), stems from two sources: professional workers in the field of aging who tend to see those elderly who do not have normal family supports and childless old people who compose one-fifty of the elderly population and may have a tendency to believe that the aged are neglected by their children. Saul (1974, p. 26) contends that old people are often brought to institutions or remain there simply because there are no community facilities to service their partial dependency needs. With the highest public visibility of old people being at the point of crisis or illness, it is perhaps not surprising that exaggerations may persist because these

emergency periods reflect situations where money problems, severe health needs, and lack of family help can combine to create a demand for social services and removal from the community.

Indeed, the myth of family abandonment may have some influence on families who are anticipating the increasing dependency of aged parents and who may overreact to the need for outside support by opting for complete institutionalization before all their internal resources have been thoroughly explored.

The importance of reviewing the array of popular images concerning the aged and specifically the aged parent is in sensitizing the intervention agent to his socialization which, in all likelihood, has not prepared him to serve older families. Descriptions have been offered of how easily care-givers can become brainwashed into believing the cultural myths. Social workers continually need to examine critically their practice with this client system in order to develop appropriate skills that relate to the specific needs and which inform and build on the still limited knowledge base. Beyond that, there is a need among those doing practice to understand the larger issues involved in their work. Kuypers (1977, p. 18) has claimed that:

> ...expectations of decline, loss, decay and social marginality persist despite substantial evidence showing that late life, for most, does not portend radical transformation in body and style...

He calls for a change in our perspective on late life - one that accounts for both the liberating as well as the debilitating features. The framework that he is recommending is one that treats aging as a process, transitions through life as opportunities for growth, and death as an issue not

only old people have to face:

> ...and aging is the intermittent attention, throughout life, to concerns about meaning, death, usefulness and time... (1977, p. 19).

The challenge contained in the foregoing is a significant one for workers in the field. It demands that one be constantly examining what is myth, what is fact, and engaging the older family in innovative ways to discover what the reality is for them.

The writer will return now to the question posed at the outset of section - what are the negative events as distinguished from the expectations that may in fact imperil the family life of older people? Recognizing the need to maintain a balanced view of old age, helpers must also understand various processes in elderly family members that do cause difficulty, sometimes to an extreme degree.

Role Change

One of the fundamental elements in most discussions of the aging process is that of role loss. Kimmel states that,

> ...the concept of role is related to both the individual's social position and to the norms of society. A role is the behaviour that is expected from a person occupying a social position. The norms prescribe that expected role behaviour. Since many social positions have role behaviours associated with them, the social position is often called a role... (1974, p. 66).

Retirement contains within it the germ of a whole range of effects which for most persons in North America and in many industrialized countries of the world is a legislated fact at age sixty-five or earlier. The most

obvious of these is the potential reduction in one's social status ascribed by holding a job. Atchley describes retirement as "...the institutionalized separation of an individual from his occupational position" (1972, p. 102). He views the subsequent changes resulting from retiring as having the effect of limiting one's socially recognized and valued functions:

> But the older person cannot very easily misperceive the fact that being old may cause him to loose his eligibility to occupy positions he values. This is perhaps the most important impact that aging has on the set of positions a person occupies. And this, in turn, is very significant to the individual, because the positions he occupies determine the roles he plays and the roles he plays have a lot to do with what kinds of things he does. (Atchley, 1972, p. 101).

Loss of the position of employee status is often a critical one because one's range of activity becomes reduced. This limiting of legitimized activity, in turn, may remove an important source of identity. In fact, the consequences of retirement often have a double-edged quality built into them:

> ...The implications of such a policy (arbitrary retirement fixed at sixty-five) is that the worker, by his lengthy labor, has earned the right to rewards which will make his remaining years comfortable. However, it is tacitly understood that the worker is allowed to retire and receive the accompanying benefits in order to facilitate his removal from a role which he is arbitrarily considered no longer capable of playing. In these terms, retirement is not so much a system of rewards as it is the instrumentality by which the removal of those persons perceived as useless is accomplished. The older persons who are so removed suffer a debilitating social loss - the loss of occupational identity and a functional role in society. (Miller, 1965, p. 78).

The importance of the work role is that it is the 'open sesame' to numerous other roles. For example, the working male, by virtue of his occupational identity, is provided support for other roles such as head

of family. Often it is the person's job which really gives substance to his whole system of relationships. If acceptance in our society is to some degree dependent on employment status, then reaching the 'magic age' of sixty-five indeed may pose some alarming dilemmas:

> ...In other words, the retired person may find himself without a functional role which would justify his social future, and without an identity which would provide a concept of self tolerable to him and acceptable to others. (Miller, 1965, p. 78).

The potential loss of self-worth as defined by a work-oriented society is one that older family members must face.

Widowhood

For women in the post-sixty-five period adjustment to retirement from a job is less likely to be a problem facing them than for men, although this trend is changing as more women enter the work force earlier and remain in it for longer and longer durations. For the women in this age group, however, widowhood is one of the most common types of role losses. Similar to the retirement process there is a very real loss requiring compensations. One intimate, interdependent relationship has to be replaced with other more transitory but at least partially fulfilling relationships such as may be realized through contact with other widows, children, or surviving siblings. It is not difficult to imagine that the loss of a spouse is a major issue for the post-sixty-five elderly when we consider that fifty-six out of every one hundred in this group become widowed and three times more women then men lose their partners (Butler, 1973, p. 30). This change-laden event involves a multitude of adjustments -

the mourning process itself, the need to make practical decisions about where to live, disposition of the family home and possessions, and the development of new social roles. Finding new persons with whom to relate can prove difficult at a stage in life when one's circle of remaining friends is shrinking. Often, closer contact with one's children as a means of filling in the gaps created by the death of a spouse may be problematic because of distance from children and because of the unwillingness of the widow to become a burden to her family.

Widowhood does not necessarily imply an undesirable state. Atchley points out that it may be a time of reunion with friends who have been widowed already. One factor which may influence the adjustment of widows is the number of other roles available. Lopata found that in more densely settled and urbanized areas widows have more freedom in choosing activities and hence alternate roles for themselves. (Lopata, 1973, p. 221).

Multiple Losses

The process of role transition associated with retirement and widowhood involves, at times, a larger process of multiple losses. Most theorists in the field of aging consider the importance of increasing frequency and degree of loss as fundamental to the process of growing older. At the post-retirement stage and particularly for people who are aging parents, loss is indeed a constant companion. Some of the obvious deficits associated with age are death of close friends, siblings, and extended kin. Butler has commented that:

> Losses in every aspect of late life compel the elderly to expand enormous amounts of physical and emotional energy in grieving and resolving grief, adopting to the changes that result from loss, and recovering from the stresses inherent in these processes. (Butler, 1973, p. 29).

Saul (1974) argues that a combination of circumstances and simultaneous changes sometimes compound older people's situations.

> For example, he may be required to cope simultaneously with his own waning physical capacities, the loss of a spouse, a changed living circumstance, a reduced income, and the loss of work role... (1974, p. 31).

She demonstrates how the cumulative effect of crisis can affect the elderly:

> The threat of crisis hangs severely over the older person. In some instances, the changes may have been gradual, so gradual as to have been almost imperceptible...at some point, these gradual changes may culminate into a qualitative new situation that takes on the proportion of a crisis... (1974, p. 31).

Saul indicates, as does Butler, that the frequency with which one must face loss of one kind or another as one reaches sixty years and beyond demands increasing adjustment from the individual:

> ...Loss of a spouse may alter an older person's living arrangemement. Loss of his physical capacities requires a whole series of adaptations, especially in the absence of family, caring person, helping agent, or adequate economic resources... (1974, p. 31).

Economic, Health, and Environmental Variables

There are some very profound environmental, economic and physical changes occurring during the sixth, seventh and later decades each of which requires some specific discussion.

The first is the substantial reduction in income. Of immediate concern to any observer of the aging process is the disproportionate

numbers occupying near-subsistence or below income levels. Butler used the 1970 American poverty index of $1,852 yearly per person sixty-five and over (which was probably too rigid then and would be hopelessly off base now) to determine the number of persons in this category living below poverty lines. For the year 1968, it meant that 4.7 million American elderly (or more than one in four) lived officially in poverty. (Butler, 1973, p. 10). This estimate, of course, does not account for all those individuals who were marginally above this standard. Based on these 1968 figures, older people (over sixty-five) represent 10 percent of the total American population but 20 percent of the poor. Furthermore, Butler states (p. 10) that a more accurate accounting of the number of post-sixty-five poor would be 7 million. Another expert, Blanche Fitzpatrick, an economist, reports that according to a 1968 Survey of the Aged (American), over half of the aged were poor, or near-poor in terms of a very restrictive living standard established by the Social Security Administration (Fitzpatrick, 1975, p. 106).

The Canadian Senate Committee on Poverty found that

> ...nearly two-thirds of those over 65 in Canada in 1967 fell below poverty income levels. In 1970 more than 470,000 pensioners, or 28 percent of the total, had no other source of income than the Old Age Security Allowance. An additional 347,000 or 20.5 percent had an outside source of income that came to less than $62 per month. (Baum, 1974, p. 2).

These figures reveal a severe financial crisis for a substantial portion of the elderly population. A further fact to be understood in relation to the capacity of older parents to support themselves is that many of the aged poor become poor upon reaching sixty-five when they lose

their employment income. This group of elderly simply do not have sufficient resources from pension income to sustain them in retirement.

In terms of the physical health status of post-retirement people, several facts strike one immediately. More old people in this category become sick more frequently. In 86 percent of the over sixty-five group, there are chronic health problems of one kind or another which require more frequent doctor's visits, more frequent and longer hospitalization, and more periods of illness at home (Butler, 1973, p. 11). The effects of such changes as poorer eyesight, hearing, losses of speed and response, may be far-reaching. A common characteristic of old age, according to Neugarten (1968, p. 96), is body-monitoring which begins in the middle years. This term refers to the need to concern oneself with the care of one's body and its functions in a more concerted way than before. In addition, aging and disease threatens people's sense of identity. Reactions to bodily changes in appearance resulting from aging or from illnesses can evoke shock and disbelief. A good summary of the significance of physical health to old age is offered by Tiven:

> Aging itself is not a disease and most older people are not in poor health. However, aging is accompanied by physical changes and increases the possibility of the development of chronic illnesses. Some of the more common chronic disease conditions among older people include diseases of heart, cancer, stroke, arthritis, influenza and pneumonia, diabetes, hypertension, and mental and nervous conditions. (Tiven, 1971, p. 19).

Dependency, Individualism, and Rapid Change

Three additional and fundamental issues seem relevant to any discussion of people in the post-sixty-five period. None of these are exclusive to individuals who have reached retirement; yet, they may achieve critical importance for many older persons and for members of older families.

The first issue is that of dependency. Atchley (1972, p. 189-198) described the notion of independence pertaining to the adult in old age as the normal way of living and something to be preserved. He maintains that North American culture highly values the idea of independence and that socialization teaches us to reject, (either overtly or covertly), help from others, whether family, acquaintances, or government. Paralleling this opposition to dependency is a high value placed on the state of independence. When these norms become translated into action at the latter stages of the life cycle, problems arise. When financial resources dwindle, when health affects one's ability to maintain a home or to become less mobile, the older person may be forced into a state of reduced independence which can affect self-esteem, pride, and dignity. The loss of the cherished independent status has much meaning attached to it within society at large.

Clark and Anderson (1967, p. 222) investigated the relationship of the older person's social situation to personal characteristics such as morale, isolation, and loneliness. They found that the negative attitudes toward dependency and the strong positive valuation of independence

combine to make the dependent older person miserable. In their sample, they found that the number one cause of low morale among older persons was dependency, either financial or physical.

Atchley (1972, p. 197) proposes that one of the major developmental tasks for the older person is that of accepting dependency. Interestingly, Blenkner (1965, p. 48) has examined family relationships in later life and has found that while it may be true that the aged parent does want to keep her (or his) independence for as long as she is capable, she expects to be helped by her children when she can no longer manage. Whereas Atchley sees older people's viewing reliance on children for help and services as negative, Blenkner finds this not to hold. Studies by Shanas (1962), Streib and Thompson (1960), and Townsend (1957) all support her position that older parents value some aid from their children as their capacities to function independently decrease with age. These investigations would suggest the existence of a viable family aid network. However, Blenkner's thesis does not necessarily rule out the validity of Atchley's theme concerning the great value placed by the elderly on independence:

> ...All indicate that the older person prefers to maintain his independence as long as he can but when he can no longer manage for himself, he expects his children to assume that responsibility; his children in turn expect to, and do, undertake it, particularly in terms of personal and protective services...(Blenkner, 1965, p. 48).

Butler has illustrated rather well the influence of the norm of rugged individualism on the elderly themselves. Today's sixty-five-plus population, he reminds us, were born around the turn of the century when

Spencer's social Darwinism or "survival of the fittest" was the popular social theory. The Protestant ethic, based on Calvin's philosophy of success through hard work and self-sacrifice, predominated on the religious scene. Many people have internalized these notions and sometimes carry their insistence to remain alone and self-reliant to a degree that can be harmful when faced with some of the real personal limitations which occur. This historical background can help explain some of the ambivalence the aging person exhibits toward governmental assistance such as old age pensions and senior citizens' housing. He argues that receiving aid of a financial or social nature is often regarded by the elderly person as an indication of personal failure.

Another possible source of a sense of defeat and uselessness within the aged parents' generation is the fact that they have lived through a period of enormous social and industrial change. Advances made through industrialization, scientific knowledge, and high technology may serve to reinforce a feeling of ignorance among the elderly, many of whom have less than high school education.

The next section will review the process of aging from the position of the adult child, the person in the older family who is in the so-called 'middle-aged crisis'.

CHAPTER 3

The Adult Child's Perspective

When we move to examine the older family from the aspect of the adult child, we are confronted in the literature by such terms as 'middle years', 'middle-aged crisis', 'empty nest', 'post-parental', and the like. In this section the writer will highlight some of the major themes of this period of life as they have been developed in the gerontological writing and as they have relevance for the practitioner who is attempting to gain an understanding of the adult child's position in the older family.

Before turning to the topic of middle age the writer will provide a brief outline of the concept of family developmental tasks and its application to the discussion of the older family. Duvall (1957) formulated a scheme for conceptualizing the various stages which families undergo as they move from one important phase of development to the next. The family life cycle is a frame of reference for looking at family life. In her system, successive patterns and rhythms that seem to repeat themselves in families universally are studied for information they may reveal about family growth and key transition points:

> Families develop through the family life cycle within the generational spiral in ways that are predictable. Within the family unit, individuals grow and develop throughout their lives according to universal patterns that can be traced in every family member... (p. 133).

Havighurst (1953, p. 2) defines developmental tasks as those

> ...that arise at or about a certain time in the life of an individual, successful achievement of which leads to his happiness and to his success with later tasks, while failure leads to unhappiness in the individual, disapproval by society, and difficulty with later tasks.

Duvall incorporates this idea into another notion - the family developmental task:

> A family developmental task is a growth responsibility that arises at or about a certain stage in the family life cycle. (Duvall, p. 155).

Significant family life stages delineated by Duvall are married couple, childbearing, pre-schoolage, teenage, launching center, middle-aged parents and aging family members (p. 151). It is the tasks at the launching center and middle-aged parental stage of the cycle that will concern us in this section on the adult child.

There is a growing amount of material on the subject of middle age:

> The family life cycle stage of the middle years starts with the departure of the last child from the home and continues to the retirement of the husband or death of one of the spouses... (Duvall, 1957, p. 406).

This period occurs for most couples anywhere from the early forties to the early sixties. The following samplings should provide the reader with a sense of what some of the qualities of the period are:

> I believe that it is this fact of the entry upon the psychological scene of the reality and inevitability of one's own eventual personal death, that is the central feature of the mid-life phase - the feature which precipitates the critical nature of the period. (Jaques, 1967, p. 32).

> 'You no sooner finish raising your children and get them started on their own than you have to begin caring for your parents....Maybe it's selfish but I want a little freedom now to take trips, do new things, enjoy life while we still can.' (Young, 1973, p. 38).

> We find ourselves caught in the middle between the defiance and rebellion of a fourteen-year-old, and the anxiety that accompanies the first awareness that we are getting gray, get winded after one game of tennis, and can't leap into the ocean anymore....We may also be worrying about the possibility of a gradual diminishment in our sex lives - the sudden awareness that it's been three weeks and we hadn't even noticed!....While our children have all their choices before them, and can make what they will of their lives, we are facing the unfulfilled dreams of our lives, the mistaken decisions and choices, the things left undone, probably never to be done... (Leshan, 1973, p.30).

Some of the central elements in the foregoing are an awareness of approaching death, a weakening of physical capacities, the consciousness perhaps for the first time that one's parents are becoming old, and a growing desire to take advantage of freedon from the childbearing responsibilities.

The observers of mid-life vary considerably in their interpretations concerning whether there is a true 'crisis' for people at this period. Even since MacIver (1937, p. 199 ff.) coined the phrase 'the empty nest', middle age has often been discussed in terms of abandonment, or as a time when the parents are deserted by their children and afterward feel a loss of meaning. While there may well be numerous losses experienced by many couples at the time of child leave-taking, the available evidence reveals a more complex and extensive range of reactions. The Kansas City Studies of Adult Life (1961, p. 4) suggest a decrease in overall adjustment among fifty to fifty-five year old adults which has become popularly known as 'middle-age depression'. This process may not be associated with the climacteric (a term applied to the gradual loss

during middle age of the reproductive potential in women and waning sexual desire in men) but may be a time of general upset among otherwise normal men and women (Peck, 1961, p. 4). Some investigators have noted a loss in marital satisfaction during mid-life. In a longitudinal study, Pineo (1961, pp. 3-11) found more loneliness and greater personal needs among his sample of middle-aged couples, suggesting increased dependency, and less intimacy. Deutscher (1959, p. 44) found a direct relationship between the complementarity of the roles played by the middle-aged couple and their satisfaction with the post-parental phase. Turner (1970) has emphasized the search for a new role among women to replace the loss of the mother-homemaker function:

> Although the result may be increased closeness, it may also mean excessive demands on the husband....Inability to find a new role to replace the child-rearing role leads to a drastic loss of self-esteem, sometimes resulting in mental disorder. (p. 406).

Turner maintains, however, that to summarize the mid-life period as an overall weakening or strengthening of marital and other family bonds is an oversimplification:

> The phenomenon is rather one of change, but even here the changes may be concentrated in a few roles rather than extended to all aspects of life. (p. 406).

Deutscher has observed that the challenges at mid-life do not seem insurmountable for most middle-class couples and the adaptations are not usually pathological. This seems to reinforce Duvall's thesis that successful negotiation of the marital relationship during middle-age depends upon the degree to which the couple has successfully mastered previous critical developmental phases as well as how well it manages the

tasks of middle-age. The crisis of the period, then, for her is "... essentially that of accepting responsibility for life as mature adults, without which there is despair, disappointment, and a feeling of being abandoned in the later years of live" (Duvall, p. 407).

Some of the manifestations of middle age have already been introduced. The demarcation of this phase as a distinct event in one's life is difficult because there are so many possible triggering episodes. The attainment of physical and emotional independence of children can be a signal for disequilibrium or relief or a combination of the two. The physical realities of being unable to perform one's job or daily household routine with as much energy as previously may represent the onset of a new state of being. Middle age is usually a time of real physical changes - the first obvious indications that aging is occurring. Thinning or graying hair, wrinkling skin, and a tendency to put on weight are, for many, part of the realities that cannot be ignored. It is a time when men may begin to express concern about waning stamina and their general state of health while women are often trying to maintain a more youthful appearance through the use of cosmetic creams, reducing programs, and hair tints. (The attempt to retain a youthful appearance is by no means confined to women as demonstrated by the sales of toupees and closer attention to physical exercise regimes in men). Body monitoring (Neugarten, 1968, p. 96) which is an increased concern for maintaining physical strength and appearance assumes a new importance for people at this time. For men, there may be an increasing sense of physical vulnerability; whereas, for women, concern over the physical health status of their

husbands and a rehearsal for widowhood may occur. For women, also, there may be a sense of enlarged freedom from parenting responsibilities.

Neugarten highlighted some of the psychological issues as they emerged from her investigations of 100 upper-middle class middle-aged men and women (Neugarten, 1968, pp. 93-98). Awareness of distance between the middle-aged adult and the younger generation, she found to be a common theme. A growing recognition of the fact of the parental generation's advancing age was another. Accompanying this recognition was an identification with the older generation - an evolving empathy for the trials which the parents have undergone in the course of raising a family:

> 'I sympathize with old people, now, in a way that is new. I watch my parents, for instance, and I wonder if I will age in the same way.' (Neugarten, 1969, p. 95).

The author also discovered a tendency in her sample to deny or be unaware of aging in the parents. This she accounted for as a possible attempt by the middle-aged children to keep some distance from the thought of their own approaching death.

Both sexes talked about the changes in perception of time. Life becomes restructured in terms of time-left-to-live rather than time-since-birth:

> 'There is now the realization that death is very real. Those things don't quite penetrate when you're in your twenties and you think that life is all ahead of you. Now you know that death will come to you, too.' (Neugarten, p. 97).

Time, it appears, at least within this sample, can have a double-bind effect. On the one hand, it can be anxiety-provoking, denoting

finiteness; on the other, it can act as an incentive to utilize one's remaining years effectively.

'Taking stock' or 'reflecting' seems characteristic of the middle-aged person. Reviewing one's career achievements (for the male) and comparing actual performance with expectations is a typical activity. Introspection can lead to the review of numerous other areas of existence - marriage, success of childrearing, and anticipation for retirement. One of Neugarten's respondents summarized her own reflections as follows:

> 'It is as if there are two mirrors before me, each held at a partial angle. I see part of myself in my mother who is growing old, and part of her in me. In the other mirror, I see part of myself in my daughter. I have had some dramatic insights, just from looking in those mirrors....It is a set of revelations that I suppose can only come when you are in the middle of three generations.' (p. 98).

We have considered briefly, then, some of the key dimensions of aging from the perspective of the adult child. We shall now explore in greater detail the interaction of the two generations. The writer will be preparing the reader for an identification of dysfunction in older family systems.

CHAPTER 4

The Changing Nature of the Relationship of Adult Child and Aged Parent

In addition to resolving individual identity crises (related to role shifts arising from loss of children and waning physical status), renegotiating the marriage (now that the marital pair are left as the central interpersonal relationship), and adapting to the new complex of in-law relations, the middle-aged couple must begin to assume greater responsibility for parents who are becoming older. While managing to cope with their own aging process they must do this in the context of assisting their newly married children to establish separate families of their own and adjust to a changing relationship with their own parents. Each middle-aged partner occupies multiple roles in the family: husband, father, father-in-law, and grandfather, and wife, mother, mother-in-law, and grandmother, as well as son and daughter of aging parents. Hill (1965, p. 394) scrutinized mutual aid patterns in an intergenerational sample of intact families linked through three generations and found, not surprisingly, that the middle-generation was the most active in giving help on five areas of exchange - economic, emotional, gratification, household management, child care, and illness. The grandparents received more help than they gave in these categories. The married child generation gave more help in three areas and received more help in two areas.

Oppenheimer (1974, pp. 227-246) has noted that couples who complete their families at young ages (in the 40's or early 50's) have a

considerable advantage over those (in their late 50's and early 60's) who still have adolescent children at home or who have to subsidize prolonged schooling or early marriages of offspring. Lower paying occupations may not keep pace with heightened responsibilities of this kind and can result in the breadwinner's having little time to save for retirement. For such families the middle-age squeeze of responsibility can be great indeed.

Some evidence (Townsend, 1968,p.432) suggests that differences between middle class and working class elderly in their family relations are likely to be a function of structural variables. For example, more middle class old people are single or childless when compared to working class counterparts. This may help explain why fewer middle class elderly share households with children since there are fewer possibilities among the middle class for an unmarried child born late in life to be available for joint residence. Townsend believes that such differences may explain why the interdependence of the elderly middle class couple tends to be contrasted in sociological studies with the close relationship between daughters and elderly working class parents. Townsend (1968, p. 432) also has found that the differences in family relations in terms of frequency of contact and patterns of help are small.

What is the nature of appropriate adult child behaviour toward the aging parent? Similarly what can be determined as mature conduct toward the adult child generation by the aged parent? Blenkner (1965, pp. 46-59) evolved the term 'filial maturity' to suggest a level of maturity on the part of the adult child necessary for fulfillment of the filial role toward

his parent:

> ...He takes on the filial role, which involves being dependent on and therefore being dependable insofar as his parent is concerned. (Blenkner, 1965, p. 58).

She maintains that people who successfully master the filial crisis are those who can be realistic about their parents; who have been able to negotiate their own dependency-independency state from the parent and who, at a point when the older parent is becoming more dependent, have the capacity to view him as an individual with his own rights, needs, limitations, and life history (Blenkner, 1965, pp. 57-8). This is not an easy task since increased dependency of one's parent may produce powerful negative shocks to the image that one has of a parent - usually one of strength, self-reliance, and of a reliable source for the child's own dependency needs. LeShan (1973) has documented the pain felt by a number of middle-aged children as they discuss this difficult period of role change for both parties in the relationship:

> ...I found as I talked to many of my contemporaries that relationships with elderly parents seemed strong on frustration and weak on gratification...even if you love your parents very much, and have always had a good relationship with them, one man told me, it is very difficult to watch them age when you yourself are middle-aged and already have many anxieties about your own old age. (p. 266).

> '...I want to remember them differently, but even more than that, they are a constant reminder of what will happen to me in a few years, and I'm depressed and frightened.' (p. 267).

> Almost everyone I spoke to about this subject expressed feelings of guilt and frustration. Just as our parents were never in any way prepared for the fact of living a long life, so we are in many ways a first generation to have living parents when we are well into middle-age ourselves... (p. 267).

> 'The worst thing of all.' a friend told me, 'is not the financial burden, or having to spend so much time with them, or playing God

making arrangements for their living. It's watching the deterioration...' (p. 268).

Whether Lehan's sample of respondents happen to be unusually critical of the negative features of aging or not (the writer doubts this is so because there are numerous positive expressions in these vignettes also) there are, it seems, some demanding responsibilities with which the child must cope. As has been stated by the interviewer, change in the form of greater dependence can evoke fear in the child of several kinds: one sort is the fear of his own aging and proximity to death; the other is the acceptance of a sometimes very different person, one who may not conform to expectations in earlier life of a powerful, strong, parent figure.

The respondents to LeShan's questions are raising another matter - the lack of effective models for aging among current septo and octogenarians and their children. As indicated in an earlier section of the report, people who were born around the beginning of the twentieth century grew up in families whose average age spans were much shorter than today. Hence, there was not the experience with the care of parents who lived to seventy years or more. The likelihood was, for families who had surviving and aged parents, that they would have been supported within the household of the adult children and they would have maintained fairly good health throughout their lives.

The notion of parents being a 'burden' on offspring may be a phenomenon of the improved survival rates in the industrialized parts of the world. The committment of families to self-sufficiency and intactness was eminently functional in an earlier agrarian age when families were

bound together by common needs for survival. The pioneer era in North America favoured close physical distance of the generations. Young (1963, p. 40) has proposed that the pendulum may have swung from one kind of extreme, at the turn of the century (that of intergenerational cohesiveness), to too great an emphasis today on generational autonomy. She also believes that the lengthened parental life span has, at times, increased the duration and intensity of responsibility for middle-aged adults without necessarily providing for a corresponding maintenance in the quality of the intergenerational relations:

> When needs no longer fit, obligations become burdens. The fabric of personal love is stretched because now it must extend across gaps in experience...bind together ways of life that may touch each other only peripherally...
> It is not the extension of life but the extension of helplessness, loneliness, and isolation that weighs so heavily upon the fabric of family ties....When needs are too one-sided, one may not ask for anything without hurting one's dignity and self-respect. (Young, 1973, p. 39).

Blau (1973, pp. 38-57) takes the analysis of negative influence upon the adult-child-parent interaction a step further. She argues that although studies show that the aged parents do maintain contact with their children, closer observation of the nature of the relationship reveals some serious difficulties. She sees a basic conflict between a need of old people for independence and at the same time, for affection from their children. Intimacy at a distance, she asserts, does not always work. She maintains that a 'less-interest' principle (parents have more investment in children than vice-versa) may be at work in the relations of older families. As people reach retirement they enter a roleless state. They become outsiders who visit grandchildren and provide some

services such as baby-sitting but are expected to be neutral in their approach to family problems. She basically is taking the position that aged parents are not sufficiently integrated into their family systems and that as a result a kind of pseudo-intimacy exists:

> Pseudo-intimacy is not an effective substitute for intimacy in any social relationship, including filial (child-to-parent) relationships. Parents, especially after major role exits like widowhood and retirement, require role substitutes in which others appreciate their qualities and services. If they seek restitution for their losses in relationships with their children, as many older people do, they are likely to be disappointed....Children feel obligated and guilty toward their parents, but adult children do not, as a rule, need their parents because they have other "resources" - the core social roles of spouse, parent, and breadwinner - that absorb most of their time and energy. (Blau, 1973, pp. 55-6).

Without true needs and functions there can be no genuine lasting relationship according to Blau. The solution in Blau's terms, is for aging parents to seek compensation from waning filial bonds in alternate relationships with contemporaries who can share needs, interests, and attitudes.

Her approach, although interesting, is confusing. At times she is describing the relations between middle-aged parents and their children, and at times she seems to be examining the bonds of the retired parent and the middle-aged adult child. Despite these limitations, her observations have some merit. The committment of one generation to another, especially at the later stages of family development, does have its limitations. Input from family members should not be the sole source of satisfaction for older persons. Blau's position would seem to reinforce Duvall's notion of maturational stages. An obvious developmental stage for the aging couple is to find sufficient resources in the form of community activities and

outside friendships to serve as buttresses against the possibilities of reduced child, grandchild, and great-grandchild interest. However, the growing numbers of elderly point to more responsibility from society at the governmental level, as well, to provide for older families so that the aged do not suffer undue hardship when resources required (such as home care) are more than middle-aged family members can provide.

While the notion of pseudo-intimacy between third, fourth, and even fifth generations may have some validity, it can be misleading if construed as the fundamental fact of all older family connections. There is insufficient research in this area to permit any degree of generalization. As Young (1973, p. 40) has stated, it is debatable whether true intimacy ever existed in the families of a century ago. The system of interdependence then did not ensure happiness or closeness any more than independent households do now. Nostalgic remembrances of close-knit families sometimes can over-shadow the inevitable frictions and tyrannies which did exist even in the so-called 'good old days' of family life. Turner (1970, pp. 440-441) holds the view that the nature of the relationship between parents and their children after marriage is a mixture of both obligation and spontaneity. Blau, however, does make a valuable contribution to the discussion of the importance of the changing associations between parents and grown-up children. Much of the remaining review will be dealing with various aspects of these changes.

CHAPTER 5

The Response of Older Families to Crisis Points

The family, at the phase of launched-children with middle-aged parents, and post-retirement-phase grandparents, can be studied from the various interactions of each of the subsystems comprising it. Significant changes occur for each of these units. For the grandchildren there has been a process of emancipation from the parental home and a beginning of a new family structure - a marriage and union with yet another complex system of relationships. The successful establishment of a new marriage, the building of a career, and the rearing of children are major agenda for the young couple.

The middle-aged parental pair have, hopefully, accomplished the separation from their offspring and are engaged in the process of orienting themselves to becoming a couple again and developing new careers around leisure, grandparenting, community activities, and perhaps, for the wife, a new job. The aged couple may be involved in adjusting to retirement, to a smaller income, change of home, and acceptance of some of the restrictive aspects of becoming older as well as building new activities appropriate to their situation.

Each family has a history of problem-solving, crisis points, conflict-resolution, and a cumulative sense of success or failure in the achievement of goals. As has been suggested earlier in the paper, older families may not define generational difficulties as problems amenable to community or professional aid. Only after they have exhausted their capacity

to manage an aged parent's progressively helpless state on their own or until some new crisis occurs such as a serious illness or disability (i.e., stroke, hip fracture, failing vision) and their resources become inadequate, do they usually seek outside help. It is important to consider that only 18 percent of those over sixty-five have no living children and that three quarters of older people, according to one study by Shanas (1968, p. 193), have a child who lives thirty minutes away. It would appear that for a substantial number of older persons there is considerable help available during the time when they may be becoming more in need of assistance of various sorts. Blenkner (1962, pp. 308-9) has summarized the requests for help from the post-sixty-five person and his relatives from professional sources in order as follows: (1) finances, (2) housing and living arrangements, and (3) physical health. She claims that the fewest requests fall under the heading of interpersonal and familial relationships or general adjustment and morale. She elaborates on this point:

> ...one must be prepared to approach the problems of family relationships and emotional adjustment among the aged through the down-to-earth necessities of money, semi-protective living arrangements, and medical care. (1962, pp. 308-9).

Despite the likelihood that families are reluctant to engage in formal intervention around relationship difficulties involving the aged parent, the sensitive change agent should remain aware of the potential need that may exist for help with these areas of older family life as well as with survival concerns.

Difficulties of Mobilization in the Aging Family

There are a number of indicators of how well various family members can accomplish the successful rallying of support at a time of major transition for the aged parent. The first to be discussed is individuation and autonomy.

Families vary greatly in the degree to which they enable offspring to achieve independence and a capacity to maintain separate existences. Thus, inadequate resolution of emancipation from one's parents at the time of leaving the 'nest' can have implications for intergenerational relations later on. Couples who have not felt free to mature because of the continual overinvolvement of one or more parents may carry a residue of resentments with them into ongoing later life interactions. Albrecht (1954, p. 33) investigated the successful independence of a group of over-sixty-five parents from their children and found certain characteristics which they shared. She found that they tended to be realistic about their children, treating them as adults. They tended to maintain interests outside of the family but were also able to accept in-laws as members of the family and were not threatened by sharing themselves with the spouse of a son or daughter. Indeed Spark (1974, pp. 225-237) has found, in doing family therapy, that loyalty conflicts and unsettled accounts between parents and children are often lived out in the marital relationships of the children. She has developed an intergenerational treatment focus to enlarge the possibilities of constructive change in a family system where such unfinished business between

parents and grandparents is affecting one or both sets of relationships. She holds that whether nuclear families are geographically removed from their families of origin or not, there exist invisible loyalties and obligations between the two systems. She believes that it is essential that the therapist examine the interlocked nature of these bonds even when they are denied.

Spark is operating on the assumption that when an aged family member is designated as the 'client' by relatives who present at nursing homes, hospitals (including day hospitals) and other institutional and community services for the elderly, it may be the family which should be properly considered the client:

> ...Experience and practical necessity confirm that the family is the client rather than the aged member alone, since each family member feels the impact of the crisis of aging whether or not he plays an overt role in its resolution. (Spark and Brody, 1970, p. 201).

Boszormenyi-Nagy and Spark (1973, pp. 37-51) have evolved a model of intergenerational family therapy based on the concepts of loyalty, justice, and indebtedness. Loyalty is relevant to any discussion of developmental family stages because, as people move from the status of child to young adult to parent with their own offspring, the balance of their loyalties continually changes. At the stage of middle-aged couplehood, the members must balance out the direction of their energies to children, grandchildren, and aging parents. Operating as another element in all family life, according to these authors, is a sense of justice:

> ...Justice can be regarded as a web of invisible fibers running the length and width of the history of family relationships, holding

> the system in social equilibrium throughout phases of physical togetherness and separation... (Boszormenyi-Nagy and Spark, 1973, p. 54).

They include in their theory the notion of balancing out debts. All families will undergo a shift in the collective sense of having obligations to particular members. At the mid-life and late-life periods this balance-sheet of merits will have become well established. Where there has been an inequity in the manner that loyalty and obligation ties have been enacted, one can expect to find angry, neglectful parents, scapegoated grandchildren who may suffer from being the target for the unmet childhood dependency needs of their parents, and sometimes, rejected grandparents. The importance of balancing successfully the multiple obligations will be of crucial concern to the change agent when aging parents are in need.

A common type of inhibitor of effective family togetherness in late life is the phenomenon of unsettled sibling jealousy. Parents who have promoted children ahead of others, may, during an aging crisis, encounter ongoing hostility instead of sympathetic response. The 'family burden-bearer' (Brody and Spark, 1966, pp. 83-4) is a typical syndrome of families in which there has been a pattern of elevated recognition for some children at the expense of rejecting others. The martyred son or daughter can usually be identified as the victimized one who seems to be all-self-sacrificing with questionable returns for his or her efforts. She or he may appear to be gaining something from the 'burden' while other family members escape responsibility but pay for it with their own guilt.

"The function of the burden-bearer may be to maintain and support family-role constellation, even at the cost of her own individual maturation." (Brody and Spark, 1966, p. 83).

Children who have never achieved a separate identity from parents even as they themselves reach mid-life may have great difficulty with accepting the aging process in their parents. Particularly unmarried or divorced daughters and sons who either remain with the parents under the same roof or who maintain excessively close ties throughout their adult years may have a need to see the parent as indestructible. It will be recalled from the earlier discussion of middle-aged respondents that coming to terms with one's own death is a normal task for all people at mid-life. Accepting an aged parent's changing state is another. For symbiotic, overinvolved parent-child interactions the natural decline of the parent sometimes is resisted vigorously by the child. The goals for intervention with such dyads may be to assist the adult child to 'give up' the need to treat the parent as an all-powerful figure and to begin to fulfil the filial role.

Leshan (1973, p. 272) has noted instances when parents may try to seduce a child into taking over long before this is necessary. Infantilization of aged parents can lead to a lowering of self-esteem among them and perhaps robs them of the opportunity to find their own unique adjustment to the demands of old age.

In families in which the parent has assumed an authoritative, controlling role throughout life, there can be a major adjustment needed from all members when illness or reduced strength makes it impossible for

the 'patriarch' or 'matriarch' to continue to act in a dominant style. The helper may be active in getting the aged parent to accept the limitations as well as assisting the children, siblings, and those other important kin to become realistic about the change to a more dependent role.

Grauer, Betts, and Burnbom (1973, pp. 21-24) note that occasionally a domineering parent who has been abusive to his children may, upon suffering a debilitating illness, find himself getting 'paid back' by the family. They find that where there has been a history of violent, negative behaviour between parents and offspring that limited success can be expected from engagement of the family in a change process. They determine a prognosis for family treatment according to the presence and strength of 'welfare emotions'. They feel it is often possible to resolve family conflict in older families if "...there is some evidence of happiness, pride, joy, tenderness, love or sympathy, or even if the patient or the involved family mamber has experienced these feelings in the past" (Grauer, Betts, and Burnbom, 1973, p. 22). If the client demonstrates a history of gratifying relationships with his own parents or siblings, a good marriage, and harmony in the relations of his children and with the grandchildren, then it is assumed that welfare emotions have been present. It is then considered possible to help the members who are in conflict gain insight into the problems associated with the changed roles brought about by the aging of a parent and promote behavioural change. Where there has been a lack of warmth and a lack of open communication between aged couples and their children, it may be too difficult

to encourage a more flexible approach to one another.

It has been shown by numerous writers that family stability can be seriously threatened by the onset of a serious illness to the aging parent. The interplay of consequent events can affect the entire system. Miller, Bernstein, and Sharkey (1973, pp. 278-285) have postulated that the pattern of family behaviour during the illness of a parent can be a re-enactment of the way the children have been socialized by the parent to react to disease. This re-enactment may be in the form of denial or distortion of the illness in order to preserve the premorbid level of family functioning. They cite case examples of normal family defenses that contain elements of denial in the face of the pain of seeing a parent becoming seriously impaired. They also cite instances of denial that reach pathologic dimensions. They describe how these defense mechanisms may operate:

> ...Denial and/or distortion of the disabilities of an aged parent represents a major upheaval in the family structure for the resolution of the pain of the surviving members, and is poorly related to the welfare of the patient. These processes are an attempt to extricate the family from the presumed, inevitable, unavoidable anguish of either losing a parent, or perhaps, not losing a parent. (Miller, Bernstein, and Sharkey, 1973, p. 283).

Miller and associates view the techniques used by family members, both children, and siblings as well as more distantly related kin, to cope with the crisis of sickness, as similar to a grief reaction. A family's response to the stress of a severely ill aged parent may resemble the processes of denial associated with the death of a loved one. The lengthy conditioning which some in the middle generation have undergone to learn the denial of disease may contribute to the failure of many such

families to benefit from professional services. Sheps, however, (1959, pp. 448-449) documented more favourable results with families displaying an inability to accept illness in one another or in aging parents.

The capacity of the older family to coordinate its efforts around the needs of its aging parents is dependent not only on predisposing personality characteristics of the parent or long-standing idiosyncratic behaviour patterns within various family units: environmental and circumstantial effects also play a role in the strain on relations of the two generations. Johnson and Bursk (1977, pp. 90-96) explored the quality of relationships of elderly people with their adult children to determine some of the influences on the positive nature of their feelings for one another. Using a sample of 54 parent-adult child pairs, they examined the importance of health, living environment, finances, and attitude toward aging to meaningful relations. Among their findings (the usefulness of which have to be qualified somewhat because of the smallness of the sample size) were:

> ...Elderly persons who are in poorer health not only experience general difficulties in adjusting to old age, but it appears that they may also experience problems in their relationships with their children.
>
> ...At present, poor health can increase the elderly parent's dependency on the adult child with an increase in resentment by the adult child (often caught between caring for his/her own children and caring for the elderly parent), and increasing frustration of the parent with an over-all poorer relationship between parent and child as the result... (Johnson and Bursk, 1977, p. 95).

An important distinction to make, when assessing the inhibiting factors which can heighten tensions in older families, is between chronic family conflict and acute reactions that may stem from recent changes in

the parent or adult child, or both. Crises that seem to be triggered by structural changes such as loss of home, a reduced income, or a deterioration in health, may be examples of the latter. Instances that were described in the preceding pages of inadequate achievement of family developmental tasks or deep-seated antagonisms are representative of the chronic types of dysfunction. Naturally, a careful assessment is necessary to determine whether a problem is occurring in a family in which there is evidence over its history of a strong capacity to cope with stress. A family faced with a parent who has become noticeably more hostile or depressed because of some condition of aging will have different capacities to manage if it has developed patterns of sharing and mutual support. Where aging crises are being joined to an already existing atmosphere of blame or withdrawal of affection, there may be greater difficulties in encouraging committment to the parent.

Verwoerdt (1976, p. 227) notes that ambivalence may be a common element for many families undergoing strain of an aging parent. Children may be simultaneously frustrated about the parent's inability to cope with physical or mental problems and guilty over their desire to be free of a responsibility for caring for their parent. The parents may vacillate between a wish to be close to their children and guilt or resentment over their dependency. Often getting the two generations to acknowledge these paradoxical feelings can be a major hurdle in itself for the person doing intervention. The great danger of such ambivalence is in its potential for delaying action when there is serious deterioration of the parent.

CHAPTER 6

Issues for Intervention with Older Families

From the material presented to this point several issues have been identified as salient for the helping process with older families. These will be summarized below before other issues are added to the list.

1) Degree of mastery of important family developmental stages:

Failure of the adult children to achieve a sense of their own identities either as individuals or as a marital pair has been mentioned. Such failure is usually reciprocal in that the aged couple have been unable to emancipate themselves properly from their children at the launching stages of family development. This can result in difficulties for children accepting the aging process in their parents. It can, at times, also culminate in a rejection of the parents or unwillingness to cooperate with other siblings to offer help.

Long-standing disputes over indebtedness can complicate or inhibit the decision-making process related to allocating responsibility for the care of parents.

2) Presence of welfare emotions:

A family's history of mutual positive regard, adaptability to change, and effective communication patterns can have a significant bearing on its ability to negotiate growing old together.

3) History of dealing with disease or disability:

The degree to which parents and their adult offspring have opted to use denial as a mechanism to avoid acknowledgement of illness or approaching death can be an obstacle to the effective mastery of aging.

4) Presence of chronic family conflict as an appendage to critical problems of aging:

Long-standing dysfunctional intergenerational relationships may limit the potential of family members to handle new parental demands or needs.

5) Acknowledgement of ambivalence:

Guilt and anger are commonly present in both generations and can color the way each reacts to the other.

These broad outlines from clinical practice with older families can be supplemented by other considerations which lead into a discussion of appropriate strategies for intervention. In addition to the factors just enunciated, another consideration for the worker facing an older family is the changing nature of the reality facing different members. Each member will have a different perception of the older person. Sons and daughters who are geographically distant may be returning to the parents' home to try to be of aid. Other siblings may feel the pressure from their kin to offer emotional support or material input, and respond in a grudging manner. The expectations brought to the aged parents by children and extended kin will vary considerably depending upon the degree of recent involvement. Naturally, one would expect that families which

have had relatively close connections throughout the later life period would be more willingly involved in providing for the needs of their parents.

Another variable which can affect the degree of distortedness of perception relates to the degree of suddenness of deterioration in the parent. The parent or parents may deny any significant loss of function. This can contribute to a form of collusion within the family to maintain a pretense of self-sufficiency when such is no longer justified. The difficulty for the social worker is to sort out the occasionally confusing sets of perceptions held by family and to build out of these a view that is consistent with the parent's real needs. As well, it must include the children's realistic understanding of their own roles in the situation.

Spark and Brody (1970, pp. 206-7) suggest that misunderstandings carried by families toward their aged parents can be modified by inclusion of the parent in family sessions. They postulate that a normalization process can result by working with two or more generations together. They see the possibility that honest exchange between generations may help correct shared myths in the light of the current reality. Often the act of coming together as a family again with the focus on parental needs may provoke a change. A helper who opts for a 'fresh look' by encouraging members to transcend a blaming stance may succeed in unlocking some of the impasses that have been reached by siblings or parent-child sub-systems. Live interchange among relatives of the parents done in the context of the current problems confronting the senior members can be a positive instrument in shifting the spotlight from past resentments and

hurts to current realities. Such a movement presents the opportunity to the intervenor to redefine the negative feelings related to past injustices as misguided caring, rather than deliberate attempts to abuse.

The benefits to the aged parents of having a family approach taken to dealing with their concerns is an opportunity for all to see the aged parent as a real human being with his or her own weaknesses and strengths:

> His past and current reality, helps pierce the internalized and projected myths in which he had previously been considered the all-giving or non-giving, rejecting omnipotent figure. Such vital and active participation provides an opportunity for all family members to mourn over unfulfilled wishes, which in reality may never have been possible... (Spark and Brody, 1970, p. 207).

Other advantages available to families engaging in intergenerational interchange may be in freeing the members from destructive guilt or anger that prevents energies from being directed at supporting the parent. Grandparents may come to be understood, in an expanded framework, as persons who still affect, and are affected by, what goes on in the lives of offspring. They may cease to be simply the ones who are always at fault. Grandchildren can gain from such sessions too, by being relieved of carrying the brunt of unsettled accounts between parents and grandparents. Beatman (1971, pp. 30-31) has reported examples of distorted marital and parental roles among couples who continue to seek childlike gratification from their own parents at the expense of a committment to the rearing of their own children. Such entrapment at an earlier childhood developmental phase can prevent positive nurturance of the grandchildren and impede the natural growth of bonds between grandparents and

and grandchildren. The skilled practitioner may be called upon to intervene in this immobilizing kind of adult child-parent interaction in order that the parent can be enabled to acquire the filial role as the parent's aging brings an alteration in the priority of needs.

The decision as to whether a family can and should be engaged in intergenerational exchange is complex. It should be made, as in most helping endeavours, after consideration of the whole range of issues. For many aged parents and their families such attempts at reconstruction of relationships will be unrealistic. It may well be that "too much water has gone under the bridge." The residue of unresolved history is just too large. The parents may refuse any suggestion of help with a disturbed interaction. The attempt by the practitioner to widen the focus of the encounter to a family orientation may meet with refusal from the grown-up children or extended kin. In some instances more modest goals need to be struck. Occasionally the deprivation of the parent is too extreme. For example, sometimes an aged parent is so physically deteriorated that he cannot manage even the simplest tasks of daily living and resists any attempts by available family to rescue him or make arrangements for home care or institutional placement. In these situations helping the parent accept the real limits and providing supports for the family members to plan with the parent may be the main work of the helper.

Where physical disability is the source of a crisis for the parent, adjustment to the role changes which this creates may become the focus of the work of the intervenor. A considerable amount of the activity of the writer in the practicum (and this will be described in greater

detail in Chapter 8) was devoted to helping older couples accept the limitations in function of one partner when he or she was suffering from a recent serious health problem, (i.e., stroke, fractures, etc.). Also, connected to the objective of helping people accept and understand the implications of a restrictive physical condition is the need to explore with them the closely related emotional responses to these dramatic alterations. Helping both the parent and child, where appropriate, grieve the loss of physical strength, can be an important step in their overall adjustment to the aging process.

Provision of practical resources such as home care services, day hospitals, and community center activities are all included in the task of professional intervenors with the aging family. Sometimes these instrumental needs are the real priority. Many families can and do manage the support of their elderly successfully. The arrangement of environmental supports such as subsidized housing can be the important link that enables the family members to continue their viable support systems uninterrupted. The effective intervenor must be able to make the determination as to when to select constructive attitude and/or behaviour change within the family as a goal, when to opt for practical services, and in which situations he will want to offer a mixture of both. In keeping with the intergenerational focus that has been adopted in this review, any activity undertaken by the worker even with one member of the older family system, should be considered in terms of its impact on other significant menbers.

Process Issues for the Intervention Agent

The effectiveness of work with older families can depend, in part, on how sensitive the helper is to process traps. These can be understood as tendencies of the practitioner to become caught up in generational side-taking. A typical response of families seeking institutional placement of a parent is to scapegoat the parent into being the cause of all the family misery. Sometimes there may be an element of truth to such claims. At other times the casting of blame on a parent may be a part of a more complicated series of maneuvers to conceal other pertinent conflicts. A parent who has skilfully employed the sick role with his family to control their allegiance may attempt to include the helper in his guilt-provoking behaviour. If the helper falls unknowingly into such seduction he risks the possibility of losing the battle for a fundamental change in the relationship and reinforcing the destructive cycle already in existence within the family. The intervenor himself may become scapegoated by both parents and children in a kind of alliance against him when he attempts to bring into the open the touchy area of relationships. (Boszormenyi-Nagy and Spark, 1973, p. 24).

Occasionally the middle generation may become the target for the hostility of helping agents, both within institutional settings and within community service arenas. Seeing a disproportionate representation of families who are having trouble keeping aging parents sustained in a home environment, practitioners in these settings may tend to operate on the abandonment principle. This may not always be appropriate since research

(United States Bureau of the Census, 1973, b, Table 17) had demonstrated that only 3.8 to 5.9 percent of post-sixty-five elderly actually reside in institutions. Making the adult child the recipient of blame for lack of concern may be just as destructive as scapegoating the aged parent. Intergenerational intervention, then, is a mediating process - one that gives credence to the special concern of each generation in terms of the other and builds a plan of action out of those combined sets of needs.

The process of engaging older families in a change process requires some scrutiny on the part of the practitioner to his own attitudes and mind-sets. If he becomes heavily weighted down by a defeatist tone evident in the presenting family toward the potential members to deal more positively with one another, then he risks losing the family. He walks a narrow path between accepting the family's shared version of hopelessness (all the more encouraged by an internalization of negative societal attitudes toward aging) and imposing unwarranted optimism about the possibilities of growth within the family structure. Part of the dilemma facing any person charged with helping older families is that the goals for improvement in the balance of relations must occur in the context of decline of both parents and adult children. This creative tension within which the helper operates demands a philosophical orientation toward a belief in meaningfulness and evolvement at all life stages, including the later ones. Incongruence between lip-service paid to assurances that the family can benefit from the aging experience of the parent will be rendered as token if offered in a manner that suggests that the helper does not really believe his own claims.

Some of the effectiveness of the intervenor may be a function of social conditioning. The low status attached to helping older individuals and families can tend to be self-fulfilling. As Kastenbaum (1964, p. 140) has indicated, people who work with older clientele have to fight the inevitable associations that are made between the client system and the providers of service:

> ...The old person, having suffered a loss in status, might, for that very reason, be a good candidate for psychotherapy aimed at helping him come to grips with this loss....Association with a low-status patient may be felt as contamination - lowering the clinician's status in his own eyes. Besides this magical contamination, the clinician may recognize that psychotherapy with the aged frequently takes the form of support. Conventionally, supportive therapy is sometimes regarded as a second-rate procedure....Thus, to conduct psychotherapy with the aged person is to enter a relationship with a low-status individual and to employ a technic that carries a low-status connotation with respect to its challenges to professional skill. (Kastenbaum, 1964, pp. 140-141).

While Kastenbaum's remarks are directed specifically at psychotherapy, they seem to have wider implications for all those performing work with the aging family. As the number of elderly continues to grow and as their efforts to gain greater societal awareness of their intrinsic worth as people increases, hopefully so too will the willingness of older families to utilize helping agencies to service their relational and emotional concerns along with their needs for shelter, recreation, housing, and adequate incomes.

CHAPTER 7

Description of the Development of the Practicum

The choice of the St. Boniface Day Hospital as a setting for doing social work with older families was made after exploration of several alternatives. The writer began contracting in May, 1976, with Family Services of Winnipeg and then with Age and Opportunity Center. The focus, at that point, was seen by the writer to be on providing an intergenerational counselling service to families in which there were conflicts between the adult child and aging parent. It was assumed on the basis of some early reading and discussion with people in the field that this area of social work practice had been largely ignored to date.

Family Services rejected the proposal of a practicum centering on later life families because it felt that it could be committing itself to a service (after the departure of the writer from the scene) for which it did not have sufficient staff resources.

A successful contract was established between the worker and the counselling staff of the Age and Opportunity Center. The agreement reached with them was that the writer would utilize the counsellors (two professionally trained social workers) to screen incoming clients. Clients who identified intergenerational troubles or marital difficulties in aging parents were to be directed to the writer for assessment and possible intervention. While a number of clients were presented through this procedure, the area on which the writer was hoping to engage them - relationship difficulties triggered by the aging of the parent and/or

adult child - did not prove to be typical of the issues which families brought to the agency. In instances where relationship problems were a source of strain for the clients, contracting with families to attempt a change process around such difficulties proved to be hard to achieve. Resistence to efforts to get the family members together, whether the parent-child subsystem, the middle-aged couple, or the elderly couple, proved to be considerable. Some initial engaging was done but in most instances, people did not return for follow-up appointments.

Newspaper advertising of the service as a way of creating awareness in the community of a counselling service for older families proved not to stimulate much response.

Generally, it was concluded by the writer in consultation with his advisor that family problems in the elderly, whether they arise from some crisis of aging or are an extension of long-standing conflicts, are not the most likely points of entry for social work help. As the literature review would suggest, the helping process with the older family is more likely to be performed first at the level of survival needs such as health, income, and housing. It appears that only when these reality issues have been addressed in the aged parent and his family that the helper can attempt to shift the focus to other potentially disruptive matters involving a deterioration in the quality of relationships.

As Johnson and Bursk (1977, pp. 90-96) have suggested there may be a complex overlay of factors contributing to the deteriorated family relationships. Health breakdown may simply be the 'last straw' in a long series of cumulative critical events. The task of the social worker

then becomes one of sorting out the complicated web of variables until he can make a reasoned judgement as to what level to approach first. As pointed out in the literature review the contacts between helping agencies and older families seems to occur most often around a crisis point - health breakdown, lack of money, loss of spouse, etc. It is here that the worker may be called in for the first time. The skill demanded at this point of entry is in being able to determine the degree of family stability given a crisis situation, the degree to which historical issues are worsening the family's capacity to respond to the crisis, (i.e., issues of injustice, outstanding debts), and the degree to which the members are now willing to resolve such issues when faced with an emergency. In line with crisis intervention theory, family disequilibrium such as that provoked by the aging process, can be a time for growth as well as pain (Aguilera, Messick, and Farrell, 1970). It has also been noted that responsiveness to change may be greater during periods of emergency or serious threat to family stability (Klein and Lindemann, 1973, p. 438). Thus, it is contended that timely, sensitive engagement of family members, even at the extremes of need that sometimes occur in aging family members, can produce useful change for the entire family system. Brody and Spark (1966, p. 88) maintain that the social worker, at the point of being confronted with an older person who is in stress because of loss associated with aging, will have the unique vantage point of responding to the manifest problem of the older parent's need for increased care and of exploring engagement around self-defeating relationship patterns that are interfering with a satisfying family life. Even when there is an indication

of a need for work at changing behaviour among selected family members, and the family has been engaged toward this goal, the social worker must continue to be open to the possibility of refocusing back to the reality needs of the family as the situation warrants.

The Day Hospital

The day hospital at St. Boniface is a service for families who are experiencing strain around the deterioration in health of an aged member. (The service is not only for clients with families but the orientation adopted is toward working with families wherever possible). It is one of the agencies that sees families requesting help at some major turning point in the aging parent's life - deteriorating physical and/or emotional health. In this sense, then, it may be a focal point for aging families in crisis when the members are more accessible to a variety of helping approaches, including exploration of relationships, and adjustment to losses.

Before describing the stages of the writer's activity and learning process at the day hospital, a brief outline of the purpose of the day hospital will be provided. As the statement of objectives on the following pages indicates (see pages 69 and 70), the day hospital operates as a preventive and rehabilitative service to older individuals and families. These clients may come from within the Extended Care Unit of St. Boniface Hospital or may be referred by agencies in the community that work closely with elderly persons; i.e., public health nurses, physicians,

ST. BONIFACE - DAY HOSPITAL

GOAL - To maintain geriatric patient's in the community at their optimum level of function and with minimal social stress.

OBJECTIVES - 1) To carry out full geriatric assessments; clinical, functional, and social.

2) To provide a multi-disciplinary rehabilitative program; restorative, maintainance, assessment, resettlement.

3) To co-ordinate these services with in-patient hospital services and home care services.

To reach these objectives, the following processes will be emphasized:

a) Involving the patient and family in setting and meeting treatment goals and objectives.

b) Providing an educational setting concerned with geriatric care (staff, and student educational facilities)

c) Providing social relief to families

d) Providing activity functions for day hospital and in hospital patients (2ECU)

DAY HOSPITAL CATEGORIES BASED ON OBJECTIVES

RESTORATIVE- improvement in function is the objective
Reduction of disability

RESETTLEMENT- where the patient requires supervision in adjusting to his home environment within the limitations of his disability.

ASSESSEMENT- new patients until objectives are set

MAINTENANCE-

1) Star-social relief or a stimulating experience required. No improvement expected in patients of environment

2) No star-clinically unstable Continuing professional supervision needed to maintain function

home care services, etc. The goals are wide-ranging - everything from improving overall function of an older person to maintenance of current adaptation.

The day hospital mandate is carried out by a team of approximately nine members representing Medicine, Physiotherapy, Nursing, Social Work, Occupational Therapy, Activities, Dietetics, and other specialties which are included on an ad hoc basis as need dictates, (i.e., speech and hearing experts). The team approach to delivery of services to elderly people is regarded by the institution as a potentially effective way to integrate the range of available services within the institution and from the community. No attempt will be made here to document the rich literature that has developed around the concept of teamwork in the helping professions. The direction taken here will be rather to describe generally how this team delivers its service to the aging family and the role of the social worker on the team.

By means of a process of regular reviews the team meets to assess the needs of clients. Objectives are set according to an integrated picture of patients' needs derived from the perspectives of all the aforementioned disciplines. Coordination and accountability of the activity with clients is performed by a team leader, a registered nurse.

The job of the social worker in the day hospital is multifaceted, as can be seen from the job description included (see pages 72 and 73). The worker is expected to provide the team with a social assessment of the client and provide counselling to individuals and/or families according to goals established by the team.

DAY HOSPITAL JOB DESCRIPTION October 1976

The goal of the Day Hospital is to maintain geriatric patients in the community at thei optimum level of functioning and with minimal social stress. The objectives are to carry out total geriatric assessments, to provide a multi-disciplinary rehabilitative program and to coordinate these services with in-patient hospital services and home care services.

The services in Day Hospital will be delivered by a multi-disciplinary team of which the social worker will be an active member.

JOB DESCRIPTION

Responsible to the Social Work Coordinator for E.C.U. and to the Day Hospital team, the social worker will provide the following social work services:

1. Assist in assessment of community based persons requesting services of E.C.U. and recommend appropriate service to A/D Committee. Prepare patient and family for appropriate services.

2. Based on team decision refer unsuitable Day Hospital candidates to appropriate community resources.

3. Obtain and present social assessments of all patients attending Day Hospital to be used by the team in planning and implementing treatment programs for the patient and his family.

4. According to individual treatment goals social work would provide individual, marital and family counselling.

5. In conjunction with treatment team prepare and implement group treatment programs according to special needs of Day Hospital patients and their families.

6. Identify and make referrals to social service resources in the community, act as liaison person with these resources and provide follow-up of the implementation of these services.

7. With treatment team provide crisis intervention for Day Hospital patients in the community in order to prevent unnecessary hospitalization.

8. Provide selected follow-up of patients discharged from Day Hospital program.

9. Participate in planning and implementation of overall Day Hospital program.

10. Will participate in both givingand receiving education within Day Hospital, the E.C.U. and the community.

.....2

11. Will participate in research as required by the Extended Care Unit.

12. May be called upon to act for the Unit Coordinator or other social workers during the latter's absence.

13. May be called upon to provide learning experiences for social work students.

14. Will be available for consultation to other social work staff in the area of specific expertise.

15. Expected to participate in staff meetings, staff development sessions and staff committees as required by the Social Work Department.

16. Maintain written records ans statistics as required by the Unit and Social Work Department.

QUALIFICATIONS

A trained Social Worker, B.S.W., or M.S.W. with community development, group work, individual, marital and family counselling skills and an interest in gerontology.

Liaison and referral to other social service resources in the community, follow-up, and crisis intervention to day hosptial patients in the community are among other roles expected of the social worker on the day hospital team.

Steps in Setting Up the Practicum

The first task of the writer was to secure entry into the Extended Care Unit at St. Boniface. This was done through negotiations with the director of the unit and with the Social Work Department coordinator. A social worker who had been attached to the day hospital for the previous two years was consulted regarding the day hospital as a resource for the practicum. The Social Work Department of the hospital identified a need for a more intensified family counselling role within the day hospital than had been previously possible for one social worker with numerous responsibilities to do. This need was matched by the writer's interest in working with older families.

Initial committee meetings were held with representatives from the Social Work Department, to formulate a proposal for the practice. It was ultimately agreed that the writer would operate as a member of the day hospital team working closely with the staff social worker who screened potential cases. She acted as liaison person to the team for the writer, keeping him up-to-date on clients on days when he was not present. The major advisor for the committee provided coordination of the committee activity and much of the theoretical framing of the practicum. Supervision of my work with families was provided primarily by the Social Work

Field Instructor at Family Services of Winnipeg. An instructor in Inservice Education in the Extended Care Unit (formerly team leader of Day Hospital) provided supervision and consultation on case management periodically. She also assisted during weekly team discussions of clients with whom the writer had involvement.

The Team Process

In this section an attempt will be made to summarize for the reader important themes that arose out of participation in the day hospital team. The emphasis will be placed on practical knowledge gained from this experience and generalizations that seems relevant for other social workers practicing in this role in a geriatric setting.

An overriding issue which coloured much of the writer's activity in the day hospital was gaining the acceptance and trust of other team members. Part of this process relates to the gaining of credibility with the team. The writer contracted to work on the team within the day hospital on a weekly basis (attendance was not always every week; it depended on course committments and case situations) during the period of the practicum, (October, 1976 to April, 1977). Additional time was spent outside of the hospital conducting sessions in clients' homes. Especially in the early stages of establishing contacts with team members, meeting clients, and becoming acquainted with the day hospital procedures, more time seems to have been required. Throughout the early stages of practice consistent attendance at the day hospital proved to be important. Getting the individual team members familiar with the purpose of the

practicum - for which clients it was intended and how to utilize my input in relation to the respective services other disciplines were offering - was and is one that cannot be hurried. The writer discovered that operating within the framework of a number of varied disciplines, several of them oriented to a fairly strict medical definition of a client's problems, meant that considerable time was needed to interpret and frame issues in terms of a more social systems approach. This meant that many of the decisions made concerning patient care tended to be made in terms of the immediate physical treatment deemed appropriate. It was often up to the social workers present to present the broader view of emotional and environmental forces impinging on the patient's life.

The limited amount of time spent engaging the various team members in the beginning of the practicum may have had some bearing on their not fully understanding the nature of the intended activity. Also, occasionally, the writer was not fully informed about the ongoing changes occurring in clients. The transactions occurring from day to day between clients and treatment team were sometimes missed by the writer mostly because he attended on a part-time basis and especially earlier in the process, this led to an incomplete perception of the progress of the client. The fact that the other team members were relative newcomers at the time the writer arrived also added to the difficulty of becoming integrated into the team. Others too were struggling with the process of learning their respective roles and learning how to interact effectively as a team.

A fundamental issue for this practicum (and it is assumed for any practicum within a multidisciplinary health team) is the importance of

investing a sufficient amount of time becoming visible to the other members of the team. This means, in practical terms, full-time attendance in the first month or perhaps two months of the practice. As in all group situations (and the team is a group) there is always a period of relationship establishment necessary for a person to be accepted fully as a member of the group. All students entering a practice arena face the dilemma of having to divide their time between course work and practice. This division of loyalty assumes added importance when it is occurring in a team situation where one's committment has to be invested in a larger number of people.

In the early stages of the practice, the writer operated more as an individual practitioner than as team member. To some extent it appears that the writer's interests lay in his impact with clients without sufficient consideration to the effect of the inputs of other disciplines on the client. Gradually, the necessity of the involvement of the team members in all decisions, interactions, and change processes related to the client became more obvious. One of the major pieces of learning for the writer was that the team is the focus of all client service. Ultimately the perspective the social worker brings to the team has to be interpreted clearly enough and consistently enough in order that the message is transmitted. Similarly, receiving the valuable input which other team members have to offer from their transactions, can enrich the possibilities for the worker with the client and family. Monitoring changes in clients' functioning can be crucial if the social worker is to be aware of ongoing growth in the client. An example of how feedback from team members contributes to the

understanding of clients occurred when the team leader was conversing with an old man who had been extremely withdrawn. From her unique position as a nurse working with him as a patient during regularly scheduled day hospital activities she learned that he was disheartened over his wife's assuming an arbitrary role in completing an income tax return (the patient was unable to do so because he had suffered a stroke). This information was passed on to the writer who was able to incorporate it into the intervention with this couple. It enabled the writer to have a better grasp of some of the role change factors that were affecting this couple as a result of the husband's illness.

This reciprocal kind of interaction seems very much central to the success of the team with which the writer was associated. One of the roles for the writer was as a mediator between the home situation, family dynamics, and the day hospital perceptions of the client. This is very much a process of negotiation and what is required of the social worker is an ability to first understand the orientation of all the systems involved with the client-family members, neighbours, community helpers, team practitioners, the institution at large; and secondly to create out of this understanding an assessment which accounts for all the levels having an impact on the client's life. The social worker is not the only person on the team who has this responsibility - in fact it falls on all the members to integrate the various views into a unity. However, the social worker has the advantage of being in contact with the home environment and seeing the interplay of factors that affect how the client is functioning within the day hospital.

The social work profession, because of its committment to the person-in-the-environment concept, has a significant role to play on a team such as that in the day hospital. The knowledge which the social work profession has of group process and the interactional nature of physical illness or disability with effects in the emotional sphere is a major component to any team that includes medical specialties.

Offering an educational input to the team was identified by the writer as another important role for a social worker on the team. On one occasion the writer was able to offer support to several therapists who were experiencing frustration with the slowness of response of one eighty-year old stroke client to physio and occupational therapy treatments. Some of the hostility and resistance offered by the client was reinterpreted by the writer as indications of improvement in the client who had been very withdrawn for several months. By redefining the small gains the client was making in their programs and evoking feedback from nursing staff who had also noticed some increased involvement in their contacts with him, the writer was able to encourage a more hopeful outlook in these team members. They were able to adjust their expectations somewhat and were encouraged to look beyond the man's limited talkativeness to detect some of the non-verbal clues he was giving, such as increased eye contact.

One client who typified the importance of the social worker's role of presenting the added dimensions of outside forces on clients was a sixty-one year old man who had suffered a stroke and was attending day hospital for strengthening of paralyzed limbs. In this situation the man's

wife was as much the client of the day hospital as he. Her needs had been largely overlooked in the process of his getting treatment. The writer assumed the job of advocate for this lady to the team. Advocacy by the writer led to a clearer picture of this woman's situation which included being on twenty-four hour call for her husband who needed some assistance with basic self-maintenance (baths, going to the washroom, lifting in and out of chairs, etc.). As a result of the picture presented by the writer, the team moved from viewing this lady as a troublemaking, ungrateful shrew to understanding her as a woman who was trapped in a major role change (head of the house) and a restricted life style that left her feeling exploited, exhausted, and isolated.

Later in the year the writer assumed an even more intense advocacy position when the client's wife was expressing the need for a break from her routine. Arrangements were made through the team coordinator, team doctor and the hospital, for a temporary hospital admission of the husband so that the wife could obtain a two-week rest with her sister and family. This social relief admission was regarded as necessary by the writer for the capacity of this couple to continue to cope with their situation.

A sub-role for the social worker on the team that appeared to be relevant from this practice experience was in ensuring the maintenance of congruence of goals for older clients. By being involved in assessing total family interaction the social worker can contribute significantly to the establishing of valid objectives for clients. The C. couple offer an illustration of this point. The team initially identified a need for Mrs. C. to become less protective of her husband who was suffering from multiple

problems - stroke, brain damage, confusion, and perceptual impairment. He needed to be fed and closely supervised in most activities of daily living. The goal attempted with the C.'s was to encourage the wife to have her husband learn to feed himself independently so that she could be freer at home and he could gain some degree of competence and independence. It also meant she would have to be prepared to tolerate a certain amount of mess at mealtime during the time while he was learning to feed himself. The writer found, after seeing them together, that she expected to care for her husband even to the extent of feeding and dressing him. She at times would complain about the very real burden of looking after him but could see no point in encouraging his self-reliance. It meant more of a hassle for her to get him to do some of his own self-care because the resistance from him would be too great. His limitations were indeed considerable. What the team regarded as a desirable level of independence conflicted with what the couple really wanted. She was by now accustomed to the role of providing almost total care and it was obvious that any attempt to alter the pattern was going to be met with failure. What the wife did want was periodic, short-term admission so that she could be relieved of her duties occasionally. After this information had been shared with the team by the writer, objectives were modified for Mr. C. Intermittent social support to the wife through periodic admission was regarded as a way of providing the wife with the break she needed to continue to maintain him at home.

The C.'s represent a situation in which the initial assessment established originally by the team conflicted with the goals of the couple.

Greater independence was not something that either party really desired. The writer's role was to review with Mrs. C. her notion of what she required of the day hospital. The social work contribution toward a fuller understanding of this couple was in clarifying their real expectations to the team.

This chapter has been a brief outline of the evolution of the practicum from counselling intervention with older families in a community-based setting to a helping role within a health care institution servicing the elderly.

A description of the multidisciplinary team was given including the responsibilities of the social worker on the team. Some conclusions were drawn by the writer from his participation on the team. In particular, regular attendance, accessibility, and building trust and credibility with all the team members were reported as crucial requirements for social work effectiveness. Examples were offered by the writer of several key roles that can and should be played by a social worker on a health team such as this: advocate, contributing to a broadening of the team's perceptions of clients throught the knowledge of home environment, and educating the team members toward a holistic social systems perspective of the client.

Next, the writer will attempt to demonstrate where integration occurs between the theories of intervention with older families that have been presented and his actual practice with day hospital clientele.

CHAPTER 8

Connecting Intervention Theory to Practice with the Older Family

An attempt will be made here to integrate theories of intervention reviewed in Chapter 7 with actual practice with day hospital families. The format for this integration will be to select issues from the intervention theories which seem to be present in the writer's case material and to describe the activity conducted by the writer with the various families. This distinction between issues of helping and work performed is in reality an arbitrary one since true practice is composed of a fusion of both knowledge about the salient issues for intervention with a given client system and the application of appropriate procedures to that system to produce desired outcomes. It should be understood then, when reading this chapter that skills in practicing with older families and indeed with any client system are a blend of both knowledge and activity. The literature that has been reported on by the writer pays more attention to broad themes for understanding dynamics at work with older families than it does to the details of how to intervene. The writer intends to elaborate on the actions he took with his clientele in order to make the integration of theory with practice more complete. The approaches adopted by the writer are derived from a combination of reading, supervision, and contact with older family clientele.

The reader is forewarned that these interventions were not conducted

in isolation by the writer but were done within the framework of full consultation and negotiation with the day hospital team. The writer will be examining in a limited way how other team members' practice affected the clients with whom the writer was working and the approaches he adopted with the clients. It is important to understand that the writer saw the team's process of feedback to and from other team members as fundamental to the effectiveness of his practice. In the planning and activity carried out by the writer he tried to use the input of all appropriate team members and to incorporate their views of what was happening with clients into his implementation. Further, learning how to utilize the contribution of the team to his skill with clients was a significant feature of the writer's practicum experience.

The writer will be concentrating on applying the following issues to the assessment of the work performed with day hospital families:

1) cluster of circumstances

2) finances, health, and living arrangements as an entry for familial relationship problems

3) presence of welfare emotions

4) failure of adult children to achieve a sense of their own identity

5) presence of ambivalence in one or both generations

6) sense of injustice, indebtedness, and loyalty

7) family burden bearer.

Four families well be discussed using the aforementioned categories as a framework. Not all of the issues will be applicable to each

family. Among interventions used by the writer to be discussed are problem redefinition, problem clarification, opening communications, advocacy, grieving losses, and lending support. The chapter will also incorporate feedback from clients on a questionnaire (see pages 86 and 87) given them by the writer. These responses will be examined in terms of whether they seem to support the writer's objectives with clients, and what the clients found helpful in the writer's approach.

Saul's point (1974, p.31) concerning the cluster of circumstances which sometimes conspire to create a crisis situation in older families is supported in the B. couple with whom the writer worked. Prior to Mr. B.'s stroke in 1976, his mother and brother died within the space of the previous twelve months. His wife's mother died in the spring of 1976 not long before Mr. B. suffered a stroke. For this couple there was the painful loss of two parents and a sibling all within a year, plus a severe illness which left the husband unable to work and with a much reduced income (disability pension). This series of multiple losses, combined with major role changes for each, left the B.'s in a devastated position. Mrs. B. found herself having to postpone her own grief over the death of her mother while trying to assume the very demanding task of caring for her husband. The normal role losses (Atchley, 1973) that occur with retirement were greatly intensified for Mr. B. who had to handle the added shocks of loss of physical mobility. For a man who had enjoyed many years of participation in athletics, this was an especially injurious blow to his self-esteem. The loss of income resulting from premature retirement meant restrictions of freedom for both people.

It has been almost _____ months/weeks now since we met last and I'd like a chance to talk with you about how things are going now. But before we talk about the present, let's go back a minute.

1. As you see it, what was the main or major concern/problem we were dealing with last?

2. Would you say that things have improved since then?

   If yes, explore for details.

   If no, explore for details.

3. Would you say that your contact with me or with Day Hospital helped you during that time?

   If yes, explore for details.

   If no, explore for details.

4. I'd like, if you can, for you to talk about me and what I did (or didn't) do to assist you?

On the positive side, are there things I did that you found helpful?

On the negative side, what did I do that you found unhelpful?

5. As you look back, what do you think we (include Day Hospital) could have done? Or, what would you have liked to do?

Thank you for your assistance

Grant Dunfield
M.S.W. Student

The presence of welfare emotions (Grauer, Betts, and Burnbom, 1973, pp. 21-24) was evident in this couple. Both people appeared to have strong feelings of affection throughout their marriage. Their capacity to nurture each other was a source of great strength to them when faced with the strain on relations imposed by the stroke.

Spark's concepts of justice and indebtedness seem to have relevance for the B.'s. They were a childless couple who relocated in Canada from the United States in their mid-life to be closer to their aging parents. The B.'s both provided close support to their parents as they became older and for several years prior to the death of Mrs. B.'s father, he lived with them in their home. They both expressed some resentment toward their own families at the time of Mr. B.'s illness because they had assumed a major 'caretaker' function while their siblings had not provided as much input. They had also raised a nephew through part of his adolescence due to the alcoholic problems of Mr. B.'s brother who had been unable to care for his son. They both felt an understandable sense of anger toward their families now that they had given much of their lives to their respective parents with limited support from other members, and had been 'rewarded' with a constricted life style.

Intervention with the B.'s consisted first of instrumental help in the form of day hospital attendance for Mr. B. which provided rehabilitation for him and some social support for Mrs. B. Also, some home care services such as orderly help with bathing, occasional sitter service (allowing Mrs. B. to do grocery shopping), homemaker service, and temporary hospital admission were provided.

Blenkner's suggestion that typical calls for help from older families are usually in the context of health, economics, and living arrangements is certainly evident with this couple. Indeed, the focus which brought the B.'s to the day hospital was the husband's need to regain some strength in his affected limbs. Mrs. B.'s need (and their need as a couple) was to learn how to live with the changes created by the event. In exploring with them what other concerns were relevant, the writer identified several additional issues.

Mrs. B. was found by the writer to be overprotective of her husband. This was particularly striking in their communication patterns. She would devote her energy to 'answering for' Mr. B. making it difficult for him to express his own perceptions. The writer encouraged them to practice some new ways of communicating in the worker's presence. This took the form of getting Mrs. B. to talk directly to her husband instead of using the writer as a vehicle. The object of this exercise was to lighten the burden on Mrs. B. who felt the need to be the spokesperson for the couple because of her fear of the danger that sharing her concerns might cause him to have another stroke.

In ongoing sessions with the B.'s it was noted that they had not shared some of their innermost fears about the future. These concerned the eventuality of Mr. B.'s death and what would happen to Mr. B. if his wife were to have a serious health breakdown (she suffers from high blood pressure).

Part of the writer's task with the B.'s then shifted to encouraging the wife to see herself as not always having to be 'strong' in the relation-

ship. This became particularly important as Mr. B. became more confident in the use of his legs and was able to manage more of his own care. The writer gave them permission to talk together openly about the common fears they each held about the future. The wife was then freed from having to 'carry' this anxiety inside. She was able to see that he was not going to be damaged by these revelations of her own fears, and was even able to be supportive toward her. The writer used problem-redefinition as a technique with the B.'s. They were helped to discuss together the changes that had occurred for each of them as a result of the stroke and the other losses they had suffered. The challenges facing the B.'s then became more than just receiving some rehabilitation for reduced physical strength in one partner. It became a much more involved question of renegotiating their life together as a couple. What was a realistic expectation for Mr. B.'s potential? Could she be helped to find rewards for herself even within their restricted life style?

The writer did more than just restate the problem for the B.'s. He also clarified with them what their specific concerns were. For example, Mrs. B. had a habit of masking her anxieties or minimizing her true fears about her own capacity to 'keep going'. The writer spelled these out for her in Mr. B.'s presence. She was supported by the writer in her need to share the terrifying prospect that confronted her - long-term management of her husband and the reality that he would never be able to resume working again.

It was especially important in the beginning of the writer's work with the B.'s to allow them to complete the grieving process. Several

sessions were spent encouraging Mrs. B. to talk about the loss of her mother and with Mr. B. to grieve the death of his brother and mother. This was found to be necessary before any work could begin on arriving at a new equilibrium for both of them. Part of the intervention the writer did with this couple at the beginning stages was helping them to express their anger at the injustice of their situation - anger at being caretakers for their respective parents and now finding themselves in the position of an unexpected dependency at a stage in life when they had both been anticipating the release from heavy filial responsibilities.

It is significant that the latter stages of the work with the B.'s centered on encouraging Mrs. B. to begin establishing some new goals for herself. It was evident to the writer in the sessions held with them prior to that point that Mrs. B. had difficulty in seeing the possibility of any genuine separate existence for herself beyond caring for Mr. B. She would at times despair over the fact that his limitations meant an unchanging full-time housekeeper role for her. Attempts by the writer to get her to move beyond this frozen perception were incomplete. At the time of termination of the writer's involvement with the B.'s and with the day hospital, her husband was given a two-week admission in order that she could obtain a thorough rest from managing him at home. Much longer-term work was indicated for Mrs. B. to be helped to feel comfortable enough to leave her husband alone for a few hours in the day (which in the general assessment of the day hospital team was a realistic plan) to pursue her own interests.

The B.'s in their responses to the questionnaire given them by the writer as a means of obtaining feedback on what they identified as the central issues in the help they received were in agreement on what they felt to be the main concerns. Both identified the central business of my work with them as obtaining adequate physical therapy for Mr. B. It is perhaps consistent with the nature of the service of the day hospital that the needs which this couple named were basically help with the husband's physical rehabilitation. Clients usually seek out the service first of all to resolve problems of physical deterioration. It is also interesting to note that each pointed to other forms of help which the writer provided as also being important to them. Basically their perceptions of what assistance had been offered them coincided with what the writer had assessed as pertinent objectives. Initially he asked for a review by the day hospital team of the amount of physical therapy Mr. B. was getting, based on their request. This review was done and improvement in Mr. B.'s capacity to walk with the use of a tripod was reported.

They both saw me as an advocate for getting a more intense exercise program. They also felt an important role was performed by the writer in taking a strong stand in favour of an intermittent admission for the husband so that the wife could have a rest. Finally, Mrs. B., especially, appreciated the concern which the writer demonstrated for her situation. She reported that the writer's spending time with her meant that someone cared for her and for the real difficulties she was encountering. It is also interesting that neither reported specifically on the interventions related to helping them grieve and adjust to change. This may have been

a function of the questionnaire and of the writer's not pursuing this aspect of the service explicitly enough with them. It may also be that more clarification of what they meant by having someone show concern may have revealed acknowledgement of the help with adjustment. It may be also that with this couple the physical losses associated with the husband's stroke were, and continue to be, the most significant issues. It may be that they felt they have made a sufficient adjustment to the changes and that accomplishing new modes of interaction were secondary to increasing the husband's physical mobility. However, in writer's opinion, increasing this couple's capacity to accept the changes that had occurred in their life life style and finding as much compensation as possible within their limitations was of ongoing importance for future satisfaction.

The B. couple demonstrate the multitude of levels on which skilled intervention may be required in couples when severe physical disability has occurred. There was the negotiation over appropriate physiotherapy, dealing with both persons' multiple losses, and restructuring the contract in the direction of changing attitudes and behaviour to accommodate to the new conditions of the marriage. Finally, there was mediation with the day hospital for short-term admission for Mr. B.

The O. Family - Further Delineation of the Change Process

Mrs. O., daughter-in-law of Mr. O., a day hospital patient, exhibited the ambivalence (Verwoerdt, 1976, p. 227) sometimes typical of families coping with the needs of aging parents. She had taken care of

her father-in-law for ten years ever since the death of his wife. When, in 1975, Mr. O., now in his eighties, became immobilized by an amputation, and progressively worsening eyesight and hearing, Mrs. O. began to show signs of collapse herself. The birth of a new baby within a year of Mr. O.'s loss of his leg, coupled with the care of two older children, forced Mrs. O. into additional demands that were becoming too much for her to bear. Her husband had established a pattern of abandoning her for much of the year to work in a remote hydro operation in Northern Manitoba. His eight siblings took little responsibility for their aging father. In addition, her own aging mother, who had suffered a hip fracture, was demanding to be taken into Mrs. O.'s home, despite the potential resources of six other siblings in the area.

Mrs. O. felt trapped in a complicated series of demands from which she could find no escape. Angry at her brothers and sisters for expecting her to assume responsibility for her mother and feeling guilty that she was unable to offer her mother more concrete help, she was indeed in a terrible predicament. She felt resentment toward her husband and father-in-law for the prolonged demands they had made of her.

Intervention with the O.'s involved a number of stages. The day hospital provided her with some support with the care of Mr. O. This eventually also became a burden to her because it was a major effort for her in getting him ready for the wheelchair van for the trip to the day hospital on the mornings when he attended.

Work with the family involved several sessions with Mrs. O. to

help her express her intense feelings of betrayal, exploitation, and isolation. Helping her sort out her loyalty bonds (Bozyormenyi-Nagy, 1974) and sense of injustice suffered from the abuse from her family network was an important step in the process. She had to be helped to accept her guilt over not being able to offer more care to her mother and her anger at being in the role of the family 'burden-bearer' (Brody and Spark, 1966, pp. 83-4). As the writer indicated in the section on intervention, enabling this lady to acknowledge her ambivalence was key to getting her to move to a point where she began to take action for herself. It appeared that Mrs. O. had been extremely close to her mother (daily phone contact and frequent overnight visits for many years) and that her mother had been very dependent on her. This pattern established at an earlier life cycle phase interfered later when she was wanting more relief from responsibility. It may be that through her inability to free herself from such close maternal bonds earlier prevented her from gaining much of a separate life and added an undesired pressure at these later stages. Some caution must be exercised in suggesting a failure to emancipate properly from parental involvement, however, since there were likely cultural elements operating in this family in which close connections with parents may have been a norm. Other siblings in the family, however, appear to have succeeded in distancing themselves from their mother more than Mrs. O.

The writer held sessions with Mrs. O. and Mr. O. jointly to attempt to encourage more responsibility with regard to making nursing home placement plans for the father. As already mentioned, the wife was supported in her right to her feelings and once these had been expressed, she began

to initiate action to plan a nursing home placement for Mr. O. The writer was not successful in shifting the balance of responsibility from Mrs. O. more equitably to her husband, but was able to help Mrs. O. move out of her trapped, ambivalent state and begin demanding some rights within the family for herself.

Work was also done both in the home with Mr. O. senior and when he was in the day hospital in interpreting to him the daughter-in-law's needs. Attempts were made by the writer to encourage the daughter to arrange a meeting with her family regarding sharing responsibility for the care of the mother among the other siblings. Although this did not materialize, the writer did encourage Mrs. O. to assert herself with her mother when the latter again pressured her to take her into the home. She,(Mrs. O.), reported that she had been able to take a stronger stance in subsequent contacts with her mother. Ongoing help was organized by the writer through a transfer of Mrs. O.'s case to the permanent day hospital social worker who continued to be available to Mrs. O. as a source of support after the termination of the writer's work at the day hospital. Mrs. O. continued to require support to contend with the disapproval of her husband and children over the decision to relocate the aging father-in-law. Some interpretation was done by the writer with Mrs. O.'s children regarding her needs for reduction in the degree of responsibility she was carrying. In some ways the writer was acting as this woman's advocate in her family relations in the face of a deeply entrenched set of role expectations in which even her own children had a great deal of investment. While large-scale rebalancing of debts was not

accomplished in this family, significant alterations in Mrs. O.'s methods of coping with two aging parents seemed to have occurred. This situation is also an example of Spark and Brody's (1970, p. 201) assertion that the definition of the client system in working with older families should include the entire family, not just the aged parent.

Mr. O. senior was initially the focus of help from the day hospital. He received regular exercises from the physiotherapist as well as the stimulation of the change in surroundings. The reason for the referral to the writer in the beginning was the emotional withdrawal of Mr. O. from his family. This in turn seemed to occur at a time when Mrs. O. had her baby and was able to give less attention to her father-in-law. When the daughter-in-law requested that Mr. O.'s days of attendance at day hospital be reduced from two to one, it became evident that her responsibilities were beginning to 'swamp' her. The focus of the writer's work then shifted from attending to Mr. O.'s losses (leg, sensory deprivation) to helping Mrs. O. survive the pressures she was undergoing.

Two of the techniques applied by the writer to the O. family were problem identification and clarification. Initially when the writer visited Mrs. O. after her request for a reduction in Mr. O.'s attendance she blamed herself for being unable to cope with the incredible array of demands on her time. By expanding the definition of the problem to include the responsibilities of her husband, children, siblings, and in-laws, the writer began the process of removing the sense of imprisonment this lady felt concerning the lack of alternatives for herself. Clarifying with her the nature of the confusion she felt also seemed to begin to trigger a

change toward self-mobilization in Mrs. O. The writer was able to show her how the pressures of her mother's demands combined with the ever-increasing needs of her father-in-law had resulted over time in an accumulation of emotional and physical fatigue. Helping her understand that the desperation and helplessness she was feeling did not simply reflect her own inadequacy but were the results of expectations that had become simply unrealistic gradually gave her a new perspective to view her situation.

In addition to doing problem identification and clarification, the worker lent her support to her feelings of outrage. The writer, by confronting her husband with this perception of Mrs. O.'s needs, helped her find the strength she needed, once having gotten her husband's approval, to explain to her father-in-law the necessity of his moving to a nursing home. Also the writer's role as a concerned outsider and authority figure seemed to have an impact on the husband who previously gave only lip service to his wife's pleas for him to discuss the issue with his own father.

The intervention with the O. family reveals the spiralling effect of the process of promoting change in older families. Identifying Mrs. O. as a client in this family set in motion the possibility for her to begin to ventilate her true feelings. A revised view of other family members being part of the problem seems to have contributed to her newly found strength to negotiate with both her husband, father-in-law, and mother for a different balance in her relationships with them. This situation also raises another possibility in understanding the engagement stages

with older families. Mrs. O. only became open to the possibility of changing relational patterns when faced with the limits of her own coping energy. Prior to this impasse, she denied that there were any problems for herself within the family situation. The vision of her own imminent destruction in the face of all the pressures mounting up around her altered her willingness to examine alternative ways of managing the family responsibilities. Once she had been able to express her negative feelings and once the previously taboo subject of the very strong need for alternative living arrangements for the father-in-law had been introduced into discussions with Mrs. O. and her husband by the writer, she could proceed to initiate some action. (It should be noted, also, that the heightened capacity for families to change behavioural and attitudinal patterns during crises is not confined only to older families).

The O. family is an indication of the need of an additional skill on the part of the helping agent - the skill of being sensitive to changes in coping abilities in family members with responsibilities for aging members. Yet another skill is tuning in to the influence of change within other parts of the family system. For example, it should be noted that in this situation Mr. O.'s gradually decreasing desire to be responsible for his own self-care (unwillingness to get up for breakfast, and using the toilet) were connected to the long periods of absence of the son whom the father missed greatly. This slow withdrawal of the father increased the pressure on the daughter-in-law who eventually signalled a call for help. A change in one part of the system (long absences) triggered changes in others (wife's coping mechanisms).

Mrs. O.'s responses on the questionnaire seem to confirm that the writer's goals were consistent with her needs as she perceived them. She commented that "if it hadn't been for you I don't know how I could have done it." When asked specifically what this meant she replied that she could see no resolution to her trapped state at the point when she made the request for reduction in day hospital attendance for Mr. O. senior and that she feared she might have eventually acquiesced out of guilt to her mother's request to take her into the home. This possibility frightened her terribly because as she stated, "I knew that I could never stand to go through another ten years of that" (caring for another aged parent). She identified as helpful the intermittent hospital admission arranged by the writer as a means of partial support for her, allowing her a chance to talk over her feelings and confronting her husband with the realities of her need for a change. She also felt that the writer's persistence in continually encouraging her to assert herself with her mother and husband were important in sustaining her through the crisis.

Example of a Process Trap - The P. Family

The ability of the intervenor to avoid generational side-taking (mentioned in Chapter 6) was confirmed as an important skill to cultivate in the writer's work in the day hospital through another case situation. Mrs. P. was a seventy-year old patient in the St. Boniface Hospital from September to December, 1976. She had been admitted in a coma by her daughter. Her condition was found to be related to failure to take

medication for diabetes. The family consisted of three daughters and two sons. One daughter, W., had taken her mother in to live with her since her father's death five years earlier and after a period when the mother was unable to manage on her own. Blaming and scapegoating occurred among several family members. Several of the siblings blamed W. for inadequate physical care of the mother. W. blamed her kin for lack of support. Mrs. P. felt understandably rejected at times. At family conferences held prior to Mrs. P.'s discharge there was considerable debate among family about who was going to take mother in. Added to the tense atmosphere of blame and counterblame was W.'s relationship with a new fiancée with whom she was living. Their marriage plans were unclear. The mother's presence in the home seemed a potential threat to the future of the new relationship.

Day hospital was recommended as a resource for Mrs. P. by the discharging Extended Care Unit. Referral to day hospital was desired by daughter, W., who had decided to take her mother home in keeping with her mother's wishes. She saw day hospital as a means of providing her mother with a social outlet and herself with a break from her mother whom she found demanding and clinging. Day hospital, was not, however, desired by W.'s mother.

Further exploration by the writer of the interaction between mother and daughter revealed that Mrs. P. felt the day hospital was a way of extruding her from the family. She was sharing a room with a granddaughter in a crowded home situation and her hostility toward any suggestion by W. of attendance even for a day a week in day hospital was intense.

The writer was initially seduced by the daughter's need for some relief from her mother and overlooked the mother's needs. After the initial assessment interview in the hospital to determine the appropriateness of a day hospital program for Mrs. P., the writer spent subsequent sessions with the P.'s at their home. The focus became one of redefining with them the nature of the conflict between them - mother wanted W. to stay home and care for her; W. wanted to work and help support the family income. W. was involved in a new relationship and indications from W. and other siblings were that the new fiancée and Mrs. P. were not getting along. Mother needed to feel she belonged in the family, and W. needed to be fulfilled in her new relationship and not have it threatened by her mother's demanding behaviour.

The focus of the writer in these follow-up sessions was on allowing Mrs. P. an opportunity to express her true feelings toward the idea of a day hospital, thereby lending legitimacy to her as a person with choices and rights. The subtle danger for the writer was to avoid becoming an agent of control for the hospital system and the daughter. Instead, the goal became that of being an agent for the successful balancing of the mother-daughter relationship. The writer encouraged the P.'s to understand that they each had needs, some of which conflicted. Support was lent to W.'s desire for a job, while at the same time emphasis was placed on mother's right not to be coerced into a day hospital program. Several months later upon a follow-up visit, it was learned that Mrs. P. and her daughter seemed to have reached a happier balance. W. had eventually stopped working, finding the hours too tiring and Mrs. P. was

maintaining her diabetic medication and was generally less rigid in her demands upon W.'s time. Also, Mrs. P. had accompanied W. and her fiancée to his parents' for an Easter dinner in addition to other social outings to see his relatives. W. and fiancee were planning to take their mother on a camping holiday in the summer. W. expressed her satisfaction with her mother's willingness to join in these activities. Each had apparently altered their blaming stances toward the other, and a more flexible equilibrium seems to have resulted.

The responses to the questionnaires revealed that Mrs. P. was indeed feeling pushed into attendance at the day hospital. Although she did not go into many specifics about what she understood her needs to be, she did state that the writer's helping her make a decision about what she wanted was an important service to her. This seems to support the impression the writer had that Mrs. P. was feeling coerced into attendance. It is not possible to be certain whether the restructuring of the problem that the writer did to make W. aware that her mother had to be considered as a person with the right to choose her own activities was understood by W. as having an impact on how she treated her mother subsequently. Whether they resolved their tensions independently of the writer or whether they used the writer's perspective to review their stances toward each other differently is difficult to determine. The writer's impression upon terminating with this family was that he may not have identified clearly enough with them the need for them to work out more amicable relations as mother and daughter. However, a new balance was possibly set in force by the writer simply in meeting with both of

them together and supporting the mother's need for some choices in life. This situation is also reflective of the very real pressures which sometimes exist for adult children who care for their parents in their own homes and of the multiple obligations they may feel to spouse, children, and parents. It can, as in this situation, result in some inappropriate planning even when the intentions and concern of the child are sincere. The helper's role then becomes one of getting parties to review their objectives and attempt to find more equitable ways of dealing with one another even within a limiting environment. In this situation it is possible that W. learned through the sessions with the writer and through her attempts to be forceful with her mother that she had to find a more gentle method of approaching her - one that accounted for her mother as a person.

Intervention with a Hospitalized Client
The Z. Family

The Z. family represented ambivalence in older family relations of a different order than that already discussed in a previous case example (the O.'s). In this situation it was the parent who displayed guilt and resentment about her dependency toward her children. Mrs. W., a seventy-five year old day hospital patient, was admitted to the terminal unit at the St. Boniface Hospital at the time of writer's becoming involved. The initial reason for referral to the writer by the terminal unit team was because of a confusing history of conflict between Mrs. W., her daughter Mrs. Z., and family. A pattern of periodic admission to the

hospital had become evident in the past two years during which time Mrs. W. had been found to be suffering from cancer. The admissions in the view of team members did not always relate to her cancer which had been in an arrested state for about six months, but seemed rather to be connected to periods of discord between Mrs. W., her son-in-law, daughter, and grandchildren. Hospitalization appeared to be a vehicle for Mrs. W. to escape the rejection she apparently felt while in the home.

The writer was asked by the team to explore the nature of the family relationships more thoroughly to discover if indeed there was a difficulty in this area. The goal which the writer had was to help the family members find some more comfortable ways of relating to Mrs. W. (not unlike the P. situation just discussed).

The writer obtained a brief history from the daughter, Mrs. Z. Her mother, a widow, had lived with her, her husband, and their four teen-age children intermittently for a number of years. She divided her time between Mrs. Z. and a daughter in Edmonton.

It appeared after several inhospital meetings with Mrs. W., Mrs. Z., and Mrs. K. (the Edmonton daughter) that everyone including Mrs. W. were in considerable confusion about what they saw as the priority issues. Coupled with contradictory feelings about wanting to be near her family but feeling as though she was a burden to them was the additional reality of a serious impairment of her health. It is to be recalled that Johnson and Bursk, (1977, p. 95) considered worsening health as one possible source of deteriorating relations between parents and their families. Mrs. Z. confirmed that in the past months since the cancer had been causing

her mother to be ill more frequently, she had become more confused, demanding and cantankerous. The family, the son-in-law and grandchildren particularly, found Mrs. W. harder to tolerate than previously. From the reports of both daughters, Mrs. W. had always been a somewhat transient, impulsive, and difficult person who was forever moving from one daughter back to the other and occasionally to her sister's home.

What emerged from the assessment was a picture of occasional family extrusion with fairly stable periods in between. Strong bonds of affection were observed to be present between Mrs. W. and her grandchildren, the youngest of whom had grown up with Mrs. W. from early childhood.

The writer initially spent several days establishing a relationship with Mrs. W. and helping her express feelings of rejection, fear, and guilt. It was found by the writer that she needed to talk about her plans for returning to her daughter's home and to sort out whether her daughter really wanted her. She also was trying to face seriously the proximity of her own death. The writer included Mrs. Z. in the sessions and was able to have her specify what some of the difficulties at home were. Mrs. W., she reported, wanted to reminisce about her past and generally wanted the family to spend time with her in the evenings when they would be involved in their own activities. She (Mrs. W.) had few outside friends or resources that she could use as means of satisfying her needs for companionship, and as her health worsened, she became more confined to the house.

By reassuring both mother and daughter that they indeed did care very much for each other and by restating the problem as one of the pressures

of illness affecting everyone in the system negatively, the writer broadened the focus to one that explained some of the turmoil Mrs. W. was feeling as health related.

The next stage in the work with the family was to help Mrs. W. talk freely about her approaching death. Her condition rapidly deteriorated while she was in hospital and she herself recognized that she was nearing the end. (She died of a blood clot within two weeks of this admission). The writer had to move quickly from focusing on helping the daughter prepare for her mother's return home to supporting her in her preparation for grief.

Had Mrs. W. returned home the writer would have attempted to work with the entire family to support them in having Mrs. W. back with them. This may have taken the form of the writer being available to Mrs. W. to allow her to ventilate her feelings and just be another person with whom she could feel free to open up to. Likewise, being with the family members, particularly the son-in-law and grandchildren to lend support to the discomfort they were feeling would have been another possible route to go with this situation. It became evident in talking with Mrs. Z. that one of the anxieties that the grandchildren were having concerning Mrs. W. was the possibility that she would die at home in their presence. The writer observed that there was a need for this issue to be raised with them all so that some of their anxieties could be allayed. This fear certainly seemed to have a bearing on the resentment that the grandchildren were displaying toward their grandmother at the times of previous short-term hospital admission.

This case reveals the incredibly tangled web of tensions that can sometimes build into a crisis state in older families where there is an aged parent residing with the adult children over long periods of time and when serious physical illness is an added component to the already existing pressures.

Mrs. Z. noted on her responses to the questionnaires that she appreciated the writer's being supportive toward both her mother and herself during the hospitalization period. She felt that her difficult position as the 'daughter-caught-in-the-middle' of the family strains had been understood by the writer. She also indicated that her mother had been given the reassurance she needed by the writer that she was valued and that she could talk openly about her own death.

What this family involvement meant particularly for the writer in his learning process about intervention with older families is that it may often be too late to do any intense restructuring of relationships where disease has become the urgent issue with the elderly parent. Instead, at times, the helper must concentrate on supporting the family in the changing reality of a painful recognition of approaching death of the parent. Giving support for the concern they have invested in the parent may also be a valuable part of the work in these situations.

The writer has examined four cases from his practice in the day hsopital and focused on the issues which support theories of intervention with older families as presented in the literature review. Also, he has described helping skills that he acquired from reading in this area,

supervision, and practice with the clientele.

Writer's Objectives Related to Team Objectives

The final section of this chapter will give a report on the comparison of some of the team's objectives with the writer's and where these fitted closely, or otherwise.

The B. couple: The team saw the wife as a highly dependent woman who had not fully adjusted to her husband's stroke. The writer found her not only as a person who needed help with the adjustment but also as someone needing outside resources with managing her husband. While home help services were provided, there were times when Mrs. B. just became overwhelmed with the demands of the situation in the writer's view. Where some of the team and the writer differed in approach was in how much responsibility Mrs. B. had in accommodating herself to a changed relationship and how much outside support had to be provided so that she could survive. The team, by the very nature of its location in the institution, could not always appreciate the difficulties Mrs. B. was experiencing. The expectation at times by them that Mrs. B. ought not to be finding herself worn out by caring for her husband were not realistic from Mrs. B.'s position. This resulted from the team's not having access to seeing her at home.

At times the target for change for the writer became the team and its perspective on this lady. At times the team was an obstacle to obtaining what the writer from his perspective identified as required (temporary admission). The major point of contention in this case was

getting the team to accept that the objectives set for Mrs. B. to become more comfortable with her overall situation were unrealistic and that occasional removal of the husband might be essential to preserve her own health.

The O. family: The team saw its goals initially in this situation as improving the mobility of Mr. O. senior through an exercise regime for his leg and to bolster his self-esteem. They regarded the writer as an important link with the family in exploring ways of increasing the family's interaction with Mr. O. in the home. The objectives moved quickly to a team focus on Mrs.O.'s needs for his intermittent admission when these became identified by the writer. Where the writer's goals supplemented those of the team were to work with Mrs. O. to help her negotiate with her husband for nursing home placement of the father-in-law. The team perception of the situation and that of the writer were essentially congruent.

The P.'s: The team did not consider service to Mrs. P. until resolution could be reached on whether Mrs. P. really desired the services of the day hospital (monitoring her diabetic medication, teaching the family better health care for their mother). The writer's work with the family was really in clarifying with the family and the team what was an appropriate service to them, if any. After the writer was able to clarify this further in home sessions it became evident that the needs of the family were in being helped alter relational patterns within the home environment. The connecting link between the writer's goals amd the day hospital's was in helping to determine whether the day hospital indeed could be used as a resource. Having established with the family that this

was not a possibility, the writer continued doing interventive work with the family after the P.'s were discontinued as clients of the team because their needs warranted his continued involvement.

The Z.'s: Mrs. W., the mother, was not attending the day hospital during the writer's work with her at the time of her admission and no coordination was appropriate with the day hospital team at the time. The writer worked individually with the family, with only brief involvement of the terminal unit team.

The concluding chapter will be a summary of the major themes of the practicum and will be addressed to general recommendations for future practice in day hospital settings.

CHAPTER 9

Conclusion

A number of general themes have emerged from the writer's work with eight day hospital families. These outlines for practice have application to the four families discussed in Chapter 8 and also to the other four which were not described. The writer has selected three themes for further elaboration in this chapter.

The first relates to the need of the practitioner to structure his interventions in the constantly changing context of hope and despair. With one couple the objectives that were struck with them required continual modification because they would alternate between being hopeful and being in agony over the pain of their losses. These shifts often would occur simultaneously within single sessions. This demanded an ability to switch the focus rapidly from goals related to altering behaviour and attitudes to empathizing with a pervasive sense of defeat.

The alteration in the clinical picture with older families seems to involve yet a deeper level. The prevailing issue of closeness to death seems never far beneath the surface of the transactions between practitioner and families. The fact that aging parents may be preoccupied with their own dying may tend to colour whatever interventions are chosen. With one family the mother's anxiety about her life terminating often assumed priority over concerns about the current state of her acceptance within the family. What is complicating for helpers in these ambivalent situations is that work must be performed on so many levels at the same time.

Response to the mother's desire to contemplate her own end had to be done in the context of the family's reaction to the reality of the mother's dying. Also, the daughter needed support for the concern she was showing toward her mother and help with grieving the loss of her mother. Incorporating the intervening variable of the parent's death into the family's overall adjustment becomes still another piece of the practitioner's role with older family systems.

In one case the direction taken was to concentrate on an elderly man's need to grieve the loss of his physical strength resulting from a stroke. This was the central reality for the man and any attempt to explore with him methods of compensating for the stroke before he had the opportunity to have the loss acknowledged would have meant that his real needs were being ignored. The skill of the intervenor with clients who are experiencing a sense of having no future relates to the capacity to be comfortable with people in despair. This ability is related also to the expectations which the helping person brings with him. Often we are not conditioned to the different pace of living characteristic of people who are faced with accepting the limitations of new physical realities and of the loss of meaning and hope that these may entail. The practitioner must also cope with his own ambivalence toward dying and be alert to his own internal dying process.

A second theme arising from the practicum is the effect which a change process occurring in one part of the family system has on other parts. With one mother-daughter conflict, engagement with the mother promoted favourable alterations in relations between the two and as well,

among grandchildren and spouse. In another family, helping the wife deal differently with her husband and other members may have contributed to family stability by enabling the wife to have fewer filial responsibilities. Working toward change in one part of the family also involves risks for the helping agent. Lending support to a daughter-in-law in one family meant a move for an elderly father-in-law to a nursing home, even though this was not a desirable outcome for anyone in the family. In the instance of an elderly couple embroiled in intense mutual abuse, a choice was made to assist the wife to separate based on her growing desire to do so and upon the limited possibilities for reconciliation. The possible long-range effects could be institutional placement for the husband but the practitioner must be prepared to accept such eventualities.

A third theme is the importance of crisis as vehicle through which older families can be helped to achieve improvement in relationships. The range of issues present in the day hospital families lends strong support to the assertion made by Blenkner (1962, pp. 308-9) and by Brody and Spark (1966, p. 88) that the manifest problem of the aged person precipitated by a stress associated with aging, may provide an opportunity for correcting self-defeating behaviour within the family system in addition to ministering to the immediate crisis event itself. The helper sometimes can perform a preventive mental health function by restructuring troubled interaction which may only surface at a point of intense disruption in one or more family members.

Several limitations in the practicum merit mention. One is the fact that the growing body of theory on death and dying was not applied to

the day hospital families. This seems to be an area where future practice should attempt to incorporate the existing knowledge on the helping process with families encountering death of an older member. The families with whom practice was conducted were small in number. The lessons gained in managing a larger number of families might have revealed a broader range of issues for help. Time restrictions prevented more families from being included in the client group.

The practicum did not deal in any depth with the rest of the team's impact on the clients with whom the writer worked. Only a general description was offered of how the writer interacted with the day hospital team to achieve an integrated set of goals with the selected families. As indicated in the introduction, the main purpose of this practicum was to expand knowledge of practice with older families. The skills required of the social worker on a health care team servicing older families is a specific area of learning that does warrant further study.

The writer was unable to find support for Blau's proposition in the day hospital families with which he was familiar that aged parents may suffer from superficial closeness to their adult children. What appears to need clarification is the relevance of this notion to later life families and a more precise definition of intimacy between generations. Whether relationships are less intimate at the aged parent-adult child life cycle stage than at earlier phases or simply different, because of multiple effects of changing societal conditions generally, requires more investigation.

Boszormenyi-Nagy and Spark's clinical work with intergenerational families may be limited in its usefulness to practice because of the relatively few samples of work with post-sixty-five year old parents and children. More of their illustrations refer to parents in their sixties with children who are in their forties and thirties than they do to parents and/or children in advanced old age. The principles of balancing out indebtedness, justice, and loyalty seem to have potential for all stages of family life. Further application of their model to the families with post-sixty-five aged parents is indicated to expand the viability of this framework.

The strains that have been demonstrated to exist for the adult children who are involved in fairly intense care of parents signals a need for more developmental programming with adult children. Informational group programs for adult children whose parents attend health care settings may be one method of assisting families to cope with their responsibilities better. Also, more intergenerational groups which attempt to bring together parents and children around a focus of sharing common concerns warrants testing. The intent of such a group approach would be to help families anticipate the later life phases with a long-range goal of making the experience more enriching for all generations involved.

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